

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST MARYE C. INGEBRETSON		2a. DATE OF DEATH MONTH DAY YEAR MARCH 28, 1984		2b. HOUR 7:30 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 15 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 500 VIRGINIA AVE. APT. 305		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical typist		12b. KIND OF BUSINESS OR INDUSTRY Bank			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 500 VIRGINIA AVE. APT. 305 21204	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK J. CASEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Reilly		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-12-9974		17. INFORMANT RUTH WHITTLE ADDRESS 6705 CANONGATE RD. BALTIMORE, MD. 21239	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metabolic acidosis</u> 5910 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 yrs. 10 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Severe rheumatoid arthritis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 27, 1984</u> to <u>Mar 28, 1984</u> , that (I) (we) lost saw the deceased alive on <u>Mar 27, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Frederick J. Vollmer M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-28-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK J. VOLLMER M.D.		22e. ADDRESS 6100 YORK RD. 21212							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MARCH 30, 1984		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.			
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME		ADDRESS 6500 YORK RD. 21212		25. DATE REC'D BY REG. TO ADJ. REGISTRAR'S SIGNATURE APR 2 1984 <u>John D. ...</u>					

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		06347 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Beatrice Marie Ives				2a. DATE OF DEATH MONTH DAY YEAR March 28, 1984		2b. HOUR 1:40a M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 1, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 630 Colorado Ave. 21210	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Edgar Bussey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Reilly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 212-16-3376		17. INFORMANT ADDRESS Judith I. Herfurth Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest; Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from March 5 , 19 84 , to March 28 , 19 84 , that (I) (we) lost saw the deceased alive on March 28 , 19 84 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (XXX) view the body after death.									
22b. SIGNATURE <i>M. I. Anderson</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/28/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. I. Anderson, M.D.				22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/31/84		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.				ADDRESS 6500 York Rd. Balto., Md. 21212		25a. DATE REC'D. BY REGISTRAR MAR 30 1984		25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Randall</i>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RAYMOND E JACOBSEN			2a. DATE OF DEATH MONTH DAY YEAR 3/23/1984		2b. HOUR 9:58 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 09 06 11		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. DAKOTA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO. MD.	
10. CITY OR TOWN OF DEATH REISTERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY SAME.
13a. STATE MD		13b. COUNTY BALTO.	13c. CITY OR TOWN REISTERSTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB - JACOBSEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SKELEY JACOBSEN.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 161-20-884		17. INFORMANT ADDRESS WIFE AP 4604	

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ASPIRATION PNEUMONIA**1539**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

CANCER OF COLON

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

NONE.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 1/13/84	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING FROM COLOSTOMY	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/5/84 to 3/23/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE [Signature]	DEGREE MD.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/23/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. P. CHILIMINDRIS		22e. ADDRESS 6701 N. CHARLES ST 21204	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 3/23/84	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Anatomy Board		25a. DATE REC'D. BY REGISTRAR MAR 28 1984	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner who notified the State Dept. of Health and Mental Hygiene should be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 42 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

Items 12-22a 5/22/84 mfb F#591 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										6349 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOHN RONALD JANSSEN							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3-15-84		2b. HOUR M 3PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1939		6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3-15-84		2d. HOUR M 3PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Cockeysville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 902 Coteswood Circle, Cockeysville				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Industrial	
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Cockeysville, Md. 902 Coteswood Cr., 21030			
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Janssen							15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia Novak				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-36-8304		17. INFORMANT ADDRESS wood Cr. Mrs. Barbara Ann Janssen, 902 Cotes-					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9503 IMMEDIATE CAUSE (a) Desipramine intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 3/15, 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/ingested					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 902 Coateswood Rd. Cockeysville, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 3-16-84			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/19/84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Balto. Maryland	
24. FUNERAL DIRECTOR NAME AND ADDRESS J. E. Lowell Lemmon, 10 W. Padonia Rd.						25a. DATE REC'D. BY REGISTRAR MAR 19 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell			



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IMPORTANT: If item 21 is marked as item 1E shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Emanuel JEMMISON				2a. DATE OF DEATH MONTH DAY YEAR March 30, 1984			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 28 27		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3205 Belmont Ave. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Jemmison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Riffer Whitehead			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 219-18-2365		17. INFORMANT ADDRESS Brunetta Jemmison 3205 Belmont Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Adenocarcinoma Of Lung And Bone DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR March 25, 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9000 Franklin Square Drive 21237		22c. DATE SIGNED 3-30-84	
22a. SIGNATURE Albert Lee				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22b. ADDRESS	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert Lee, M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/4/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA Owing Mills, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Ave,				25. DATE REC'D. BY REGISTRAR APR 2 1984			
				26. REGISTRAR'S SIGNATURE John Davidson Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06351

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELSIE E. JENKINS			2a. DATE OF DEATH MONTH DAY YEAR 3 16 1984			2b. HOUR 4:25 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 26 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Grocery	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7010 Dunbar Road 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Schaefer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Dietel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 215-34-8501A		17. INFORMANT John M. Mouring III		ADDRESS 3426 Liberty Parkway Balto. MD 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.H.F. 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ABCD DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. C.V.A. D.M.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hafeez A. Syed				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFAEZ SYED				22e. ADDRESS BALTIMORE COUNTY GEN HOSP.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/19/84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR MAR 20 1984		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

BP

DHMH - 16 30M 2/80
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Adele HELEN Joerndt				2a. DATE OF DEATH MONTH DAY YEAR 3-13-84			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 24 98		2b. HOUR 10 A M	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH TOWSON (21204)		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Nursing Home MANOR CARE TOWSON		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles William Zerkle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Jane HANEY		13e. STREET ADDRESS 316 East Belcrest Road		13f. CITY OR TOWN 21204	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-74-2992		17. INFORMANT (DAUGHTER) 825-2727 ADDRESS 1572 Duxbury Road		17b. CITY OR TOWN TOWSON, Maryland	
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Intermittent Cardiac Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from 27 Oct 83 to 13 March 84 , that (I) we saw the deceased alive on 13 March 84 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.							
22b. SIGNATURE Walter T. Rees		DEGREE M.D.		22c. DATE SIGNED 13 March 84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER T. REES	
22e. ADDRESS Sanctum Md 21111		22f. ADDRESS		22g. ADDRESS		22h. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE March 14, 1984		23c. NAME OF CEMETERY OR CREMATORY CRAIN & FERRIS Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE West Chester, Pennsylvania 19380	
24. FUNERAL DIRECTOR Joseph William Foster		24b. ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR MAR 14 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Blake D. JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR March 10, 1984		2b. HOUR 12:45a ^M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7 04 1908		6. AGE (IN YEARS (LAST BIRTHDAY)) 75 YRS	7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BETH STEEL	12b. KIND OF BUSINESS OR INDUSTRY STEEL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY BALTO	13c. CITY OR TOWN DUNDALK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST UNK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-09-2713		17. INFORMANT ADDRESS IDA M. JOHNSON 1808 WALNUT AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest 4280 DUE TO, OR AS A CONSEQUENCE OF (b) End Stage of Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) this hospital attended the deceased from March 5, 1984, to March 10, 1984, that (b) I saw the deceased alive on March 10, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b. SIGNATURE Waclaw Kazimierzczak			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Waclaw Kazimierzczak, M.D.			22e. ADDRESS 9000 Franklin Square Drive 21237		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3/13/84	23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.	
24. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME OF DUNDALK			25a. DATE REC'D. BY REGISTRAR MAR 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

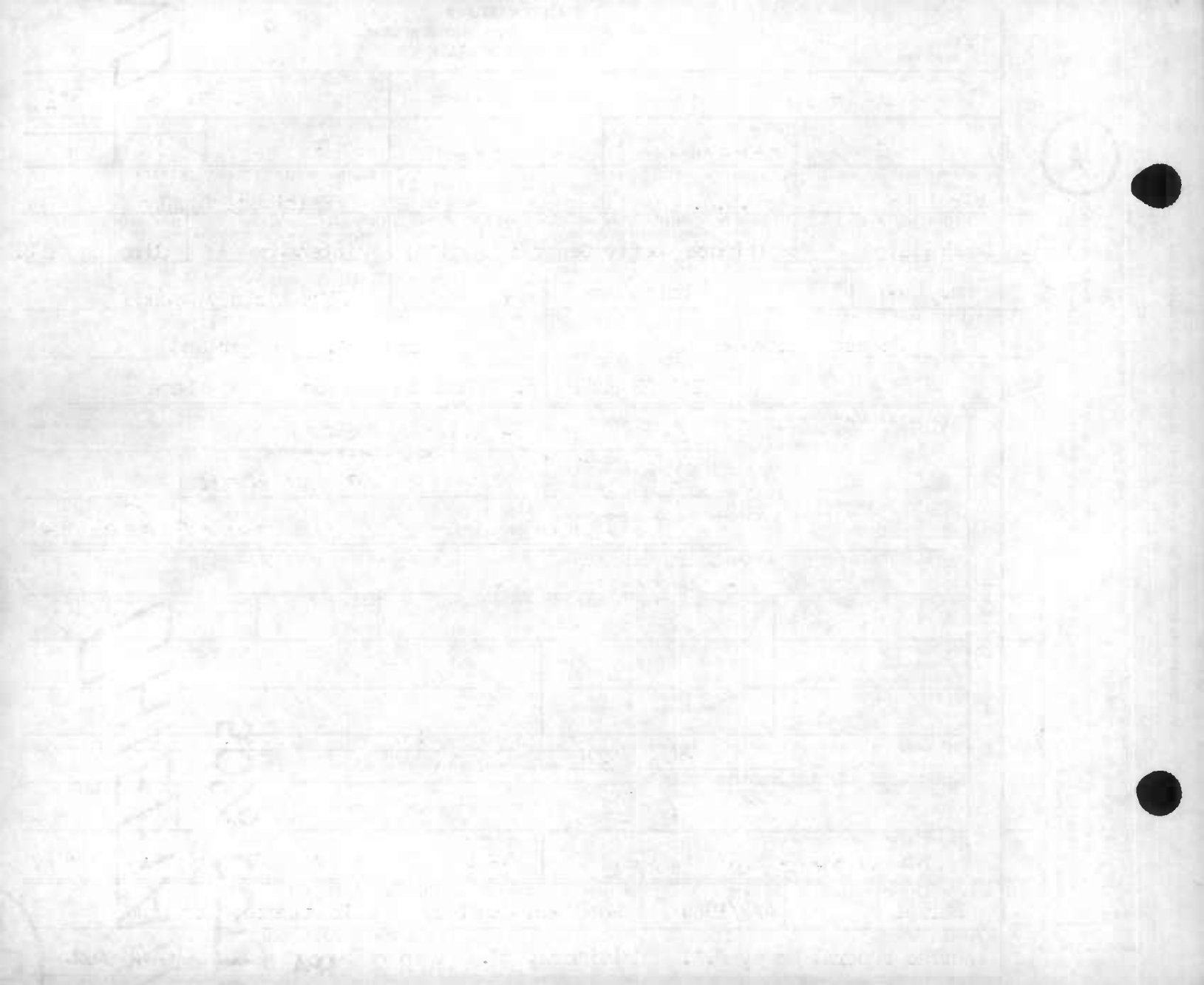
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1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARION E JOHNSON			2a. DATE OF DEATH MONTH 03 DAY 31 YEAR 84			2b. HOUR 1 36 A.M.						
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH 05 DAY 28 YEAR 10		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS. HOURS 0 MIN. 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.						
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance			12b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins U.			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3508 Hickory Avenue			
14. FATHER'S NAME FIRST Robert MIDDLE Johnson LAST Johnson					15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE A. LAST Sutherland							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213 03 6368		17. INFORMANT ADDRESS Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CARDIOGENIC SHOCK & PULMONARY OEDEMA											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. Alzheimer's Disease.												
19a. DATE OF OPERATION 3-28-84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHOLELITHIASIS				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3-27- 19 84 , to 3-31- 19 84 , that (I) (we) last saw the deceased alive on 3-31- 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE [Signature]					DEGREE			22c. DATE SIGNED 3-31-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR SUDHIR D. PATEL					22e. ADDRESS BAL - COUNTY GEN HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/3/1984		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE				
24. FUNERAL DIRECTOR NAME Burgee Funeral Home, P.A. ADDRESS Baltimore, Md.					25a. DATE REC'D. BY REGISTRAR APR 2 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine Anna JONES			2a. DATE OF DEATH MONTH DAY YEAR March 23, 1984			2b. HOUR 3:41pm			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 7 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaking	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN 7403 Kenlea Ave.		13d. STREET ADDRESS / ZIP CODE 21236		
14. FATHER'S NAME FIRST MIDDLE LAST NA Luedecke			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Richter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? no (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. 155-01-4941		17. INFORMANT ADDRESS Mildred A. Haug 7403 Kenlea Ave. 21236				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4280 Cardiac Arrest Longestive Heart Failure Syncope DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Failure Syncope DUE TO, OR AS A CONSEQUENCE OF (c) years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from March 23, 1984 , to March 23, 1984 , that (we) last saw the deceased alive on March 23, 1984 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gary D. Walford			DEGREE M.D.			22c. DATE SIGNED 3/23/84			
22d. PHYSICIAN NAME Gary D. Walford			22e. ADDRESS 9000 Franklin Square Drive 21237 Franklin Square Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-26-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Lassipho Funeral Home			25a. DATE REC'D. BY REGISTRAR BATD. MD 21236		25b. REGISTRAR'S SIGNATURE Julia Davidson				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2 of this form should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		06350	
1. DECEASED NAME (TYPE OR PRINT) Lucretia Kellogg Jones		2a. DATE OF DEATH MONTH DAY YEAR 3-2-84		2b. HOUR 4:55 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 02-9-12		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Baltimore, Md.	7b. CITIZENSHIP OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD	
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Catonsville	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never worked		12b. KIND OF BUSINESS OR INDUSTRY ----	
13a. STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 31 N. Rolling Rd. 21228	
14. FATHER'S NAME FIRST MIDDLE LAST Leonard Hays Jones, Sr.	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kellogg		16. SOCIAL SECURITY NO. 217-48-5893		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	17b. SOCIAL SECURITY NO. 217-48-5893	17. INFORMANT Leonard Hays Jones, Jr. Md. 21228.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dilated LVA - L Ventricle 3319 DUE TO, OR AS A CONSEQUENCE OF (b) Brain Atrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) -----					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: -----					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8-5-83 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 22-84	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-5-83 to 2-2-84 , that (I) (we) last saw the deceased alive on 2-2-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 2-2-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE HANCOCK		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Mar. 5, 1984	23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery-Baltimore, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Sterling Funeral Estate, P.A.		25a. DATE REC'D. BY REGISTRAR MAR 5 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
736 Edmondson Ave. - Catonsville, Md. 21228					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06357

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert B JORDAN, JR.			2a. DATE OF DEATH MONTH DAY YEAR March 3, 1984			2b. HOUR 12:05A M				
3. SEX Male		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR Dec. 3 1920		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS MONTHS DAYS				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.				
11. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Sears Dept Store		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2125 Redthorn Rd. 21220	
4. FATHER'S NAME FIRST MIDDLE LAST Robert B. Jordan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Izola Shirey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII			16b. SOCIAL SECURITY NO. 174 18 2181		17. INFORMANT Louise Jordan, Wife			ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Arteriosclerotic Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR February 21, 19 84			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 21, 19 84 , to March 3, 19 84 , that (I) (we) last saw the deceased alive on March 3, 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michael Delahunt			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Delahunt, M.D.			22e. ADDRESS 9000 Franklin Square Drive 21237							
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 3/6/84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Howard Co., Md.		
24. FUNERAL DIRECTOR Brudzinski Funeral Home PA			25a. DATE REC'D. BY REGISTRAR MAR 6 1984			25b. REGISTRAR'S SIGNATURE na Davidson-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JAMES L. JOYCE, SR.				2a. DATE OF DEATH MONTH DAY YEAR 3-22-84			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2-1-1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY - MD	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4301 SLATER AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES DEPT.		12b. KIND OF BUSINESS OR INDUSTRY CAN CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTO.				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4301 SLATER AVE. 21236	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK JOYCE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA HUBBS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-01-8381		17. INFORMANT ADDRESS 21236 Mrs. Henrietta F. Joyce - 4301 Slater Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accidental (STROKE) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas J. Zerk				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-24-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. ZERK MD				22e. ADDRESS 742 Joppa Road 2d. Joppa, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-26-84		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.	
24. FUNERAL DIRECTOR NAME ADDRESS Garthby Miller - 7527 HARFORD AVE.				25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (see page 4).

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.						
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR P M		
BERTHA LOUISE KAHLER					MARCH 24, 1984				7:00 P M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.	
FEMALE		WHITE		7 15 1901		82 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
DUNDALK		U.S.A.				BALTIMORE COUNTY, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
DUNDALK		2905 DUNMORE ROAD				CLERK		RESTAURANT			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2905 DUNMORE ROAD 21222				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
WILLIAM GEORGE KAHLER					MARY SHEFLEIN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO					215.05.5207		MARY ELLEN USHER 4516 CEDAR GARDEN ROAD 21229				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>										1 minute	
3940 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure and/or myocardial infarction</u>										2 hours	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>mitral stenosis/ischemic cardiomyopathy</u>										2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <u>3/9/84</u> 19 <u>84</u> , to <u>3/22</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/22</u> 19 <u>84</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>R. M. Hines M.D., Ph.D.</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				3/26/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
R. M. Hines				Johns Hopkins Hospital WOLFE ST. Baltimore Md. 21205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
CREMATION			3/29/1984		GREEN MOUNT CEMETERY			BALTIMORE MD			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE	
WALTER BROOKS BRADLEY, INC. BALTO., MD 21222					MAR 28 1984					John Davidson-Rendall	

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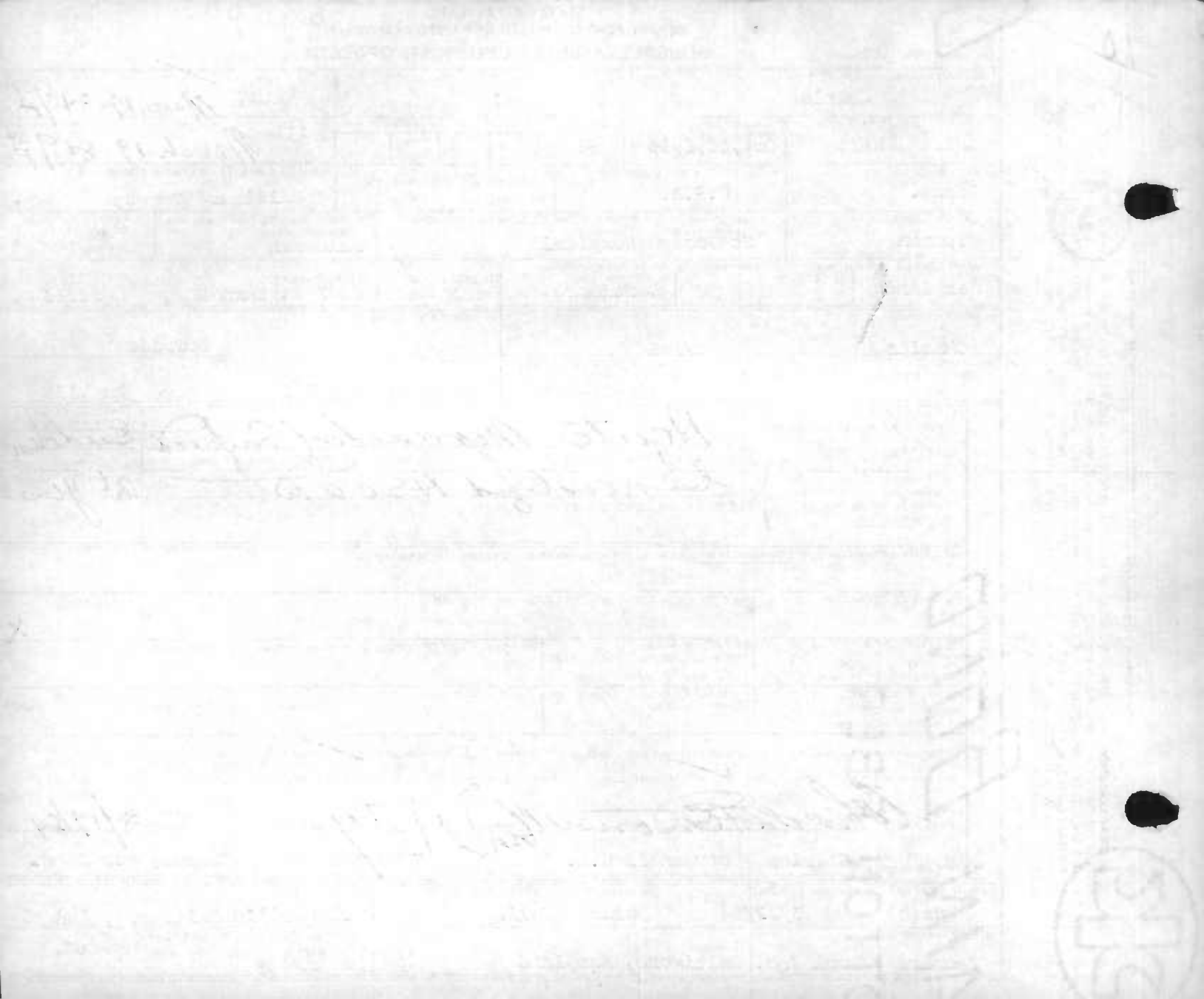
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 5, 6, 7, AND 8 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 7 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Charles G Kalil										2a. DATE KNOWN OF DEATH ESTIMATED March 19 1984	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct, 20, 1915	6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD March 19 1984		2d. HOUR 9:30 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
11. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY <input checked="" type="checkbox"/>		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6407 Eastern Pkwy 21214			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Kalil				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Bowredey							
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		14b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 369-09-9930		17. INFORMANT Mrs Gerda K Kalil		ADDRESS Same As 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF Generalized ASCVD DUE TO, OR AS A CONSEQUENCE OF (b) 2± yrs (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Charles F O'Donnell</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER Charles F O'Donnell M.D.			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 7501 York Rd				DATE SIGNED 3/12/84			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/22/84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Baltimore, Md			
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR MAR 22 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jerry			2a. DATE OF DEATH March 3, 1984			2b. HOUR 1239 P.M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 4, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 57 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Audio			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14 Sunnyking Drive 21136			
14. FATHER'S NAME Nicholas MIDDLE Karpin				15. MOTHER'S MAIDEN NAME Anna MIDDLE Fedchyna							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 229-48-9935		17. INFORMANT Stephanie Karpin				14 Sunnyking Drive Reisterstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordae Arter 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Stroke								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 79 , to March , 19 84 , that (I) (we) last saw the deceased alive on March 3, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I/US) (did not) saw the body after death.											
22b. SIGNATURE Kenneth C. Bunge			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/4/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth C. Bunge			22e. ADDRESS Mercy Hospital, Baltimore, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gar.			23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll, Md.			
24. FUNERAL DIRECTOR NAME H. J. Ehrhardt						25a. DATE REC'D. BY REGISTRAR MAR 07 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Dec. 4, 1963

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Baltimore County

U.S.A.

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Baltimore County Gen. Hospital

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Katzenbach, Mr. & Mrs.

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Baltimore County

Mar. 6, 1964, Everett Memorial Gen. Hospital, Carroll, Md.

Mar. 6, 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FANNYE KASSEN			2a. DATE OF DEATH MONTH DAY YEAR MARCH 19, 1984		2b. HOUR 4:05 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUG. 20, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND ADDRESS) BALTIMORE COUNTY GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST PINCUS SACHS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARA LEE SACHS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-48-2148J		17. INFORMANT MRS. BLANCHE PEREL APT. 208 3737 CLARKS LA. BALTO., MD 21215		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4409 Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atrial Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>General Arteriosclerosis</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 years</u> <u>10 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15/75</u> 19 <u>84</u> , to <u>3/19</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/15/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>223 Inter M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/19/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ISRAEL ZINBERG		22e. ADDRESS 6317 PARK HEIGHTS AVE. (21215)				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 20, 1984		23c. NAME OF CEMETERY OR CREMATORY GREATER BALTO. LODGE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD (21215)				25a. DATE REC'D. BY REGISTRAR MAR 23 1984		
				25b. REGISTRAR'S SIGNATURE <u>S. Davidson-Randall</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "HOMICIDE" or "SUICIDE" or "OTHER TRAUMATIC EVENT," the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06363			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FAY KAUFMAN				2a. DATE OF DEATH MONTH DAY YEAR MARCH 29, 1984			
3. SEX FEMALE				2b. HOUR 5:05 PM			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 5, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				12b. KIND OF BUSINESS OR INDUSTRY MD. DEPT. OF SOCIAL SERVICES			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3501 FOXCLIFFE CT., APT. T-4 (21133)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SOCIAL WORKER		12b. KIND OF BUSINESS OR INDUSTRY MD. DEPT. OF SOCIAL SERVICES	
13a. STATE MARYLAND				13b. COUNTY BALTIMORE			
13c. CITY OR TOWN RANDALLSTOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN POPLINGER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA BLOOM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 112-01-7312A		17. INFORMANT ADDRESS STEPHEN KAUFMAN 19225 BROOKVILLE MD. DIMAONA DR. (20833)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Renal Cell and Lung</u> <u>Carcinomas</u> 1890 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>83</u> , to <u>March</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>March 14</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Marshall A. Levine MD				DEGREE MD		22c. DATE SIGNED 3/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marshall A. Levine				22e. ADDRESS 711 W. 40th St Baltimore, MD, 21211			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/1/84		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CEM REISTERSTOWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215				25a. DATE REC'D. BY REGISTRAR APR 6 1984			

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Mr. [illegible]
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph J. Kavanaugh			2a. DATE OF DEATH MONTH DAY YEAR March 13, 1984			2b. HOUR 3²⁵ PM				
3. SEX Male.		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 11-20-10		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 73		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA Balto.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD			10. CITY OR TOWN OF DEATH Balto.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3436 Chestnut Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mutual Clerk			12b. KIND OF BUSINESS OR INDUSTRY Md. Race Tracks			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3436 Chestnut Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Kavanaugh.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Foley.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT Theresa V. Kavanaugh		ADDRESS 3436 Chestnut Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic squamous cell carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) One year APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from Feb. 27, 1983 to March 13, 1984 , that (2) (we) lost Dec. 15, 1983 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE David D. Collins MD			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/15/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David D. Collins MD			22e. ADDRESS 500 W. Univ. Pkwy, BALTO.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.			23b. DATE March 17, 1984		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City, Md.			
24. FUNERAL DIRECTOR NAME Paul E. Chenoweth					ADDRESS 3615-19 Chestnut Ave.		25a. DATE REC'D. BY REGISTRAR MAR 15 1984			
25b. REGISTRAR'S SIGNATURE John Davidson-Hendell										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) page 3 from this certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06365

FOR
1- STATE
REGISTRAR

REG. NO.

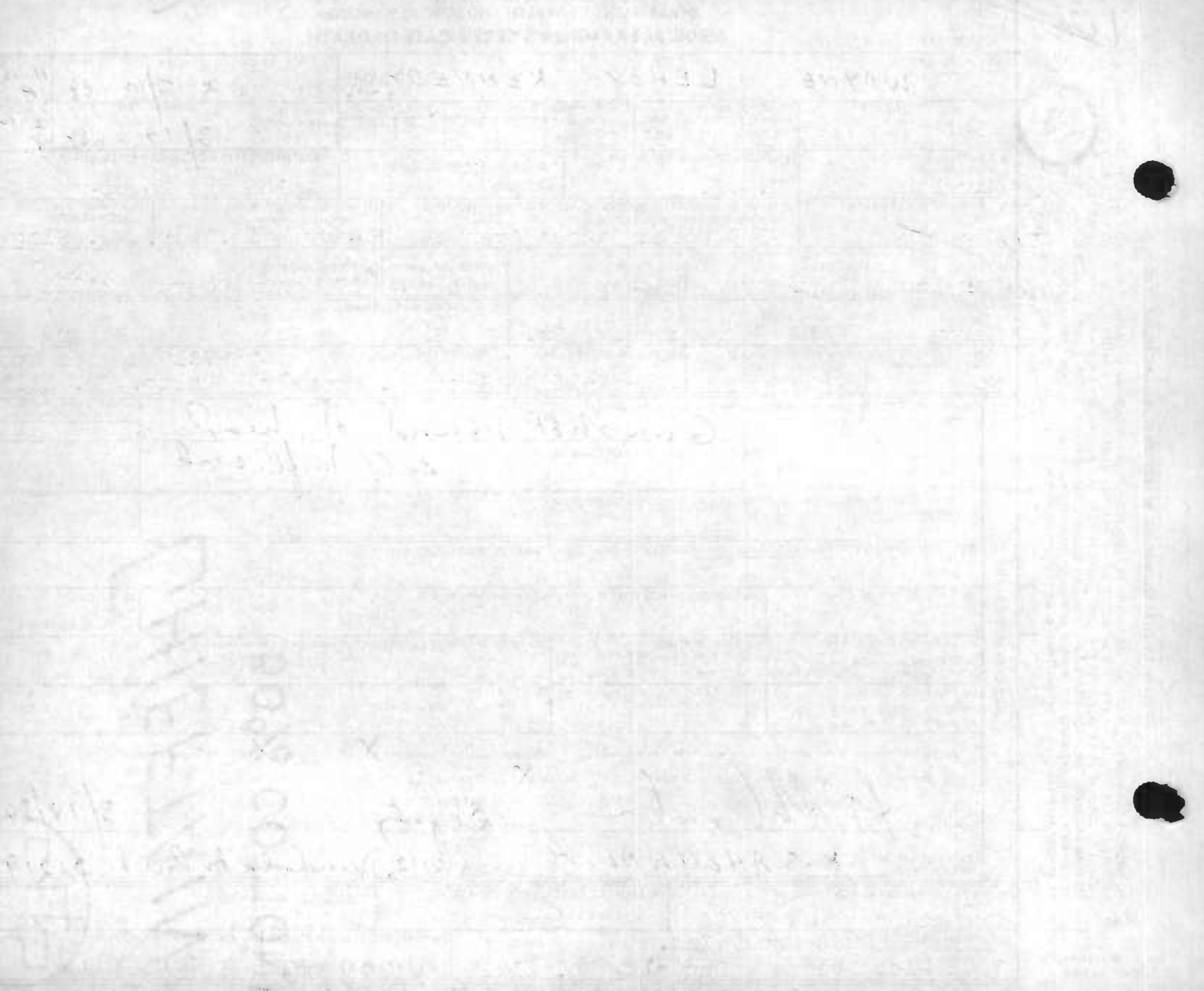
1. DECEASED NAME (TYPE OR PRINT) William Robert Kelly, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 3 25 84			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 9 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Ft. Howard		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9126 Todd Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Toll Facilities-Balto.Co.			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Ft. Howard		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9126 Todd Avenue 21052	
14. FATHER'S NAME FIRST MIDDLE LAST James P. Kelly				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Selby					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-9728		17. INFORMANT Iva E. Kelly		ADDRESS Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> 5798 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic obstructive airway Disease</u> (c) <u>Abdominal aortic aneurysm</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>69</u> to <u>3/25</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/23</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Theodore C. Patterson</u>						DEGREE MD		22c. DATE SIGNED 3/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Theodore C. Patterson, M.D.						22e. ADDRESS 3427 Dundalk Avenue, Dundalk, MD 21222			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/28/1984		23c. NAME OF CEMETERY OR CREMATORY Steel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Friendsville Maryland		
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222						25a. DATE REC'D. BY REGISTRAR MAR 28 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WAYNE LEROY KENNEDY, SR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3/19 DAY 1984										2b. HOUR 11:15 A M	
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 11 DAY 27 YEAR 51		6. AGE (IN YEARS) LAST BIRTHDAY 32 YRS.		IF UNDER 1 YR. MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 		7c. DATE PRONOUNCED DEAD 3/19 1984		2d. HOUR 2:10 P M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD									
10. CITY OR TOWN OF DEATH Edgemere				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7309 North Dakota Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heavy Equip. Oper.				12b. KIND OF BUSINESS OR INDUSTRY MD. Slag									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 17 Bonum Court 21221													
14. FATHER'S NAME FIRST Leroy MIDDLE LAST Kennedy, Sr.						15. MOTHER'S MAIDEN NAME FIRST M. MIDDLE Jean LAST Boyer															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-62-2510		17. INFORMANT ADDRESS Sarah A. Kennedy Balto., MD. 21219															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. self inflicted														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) Deputy				DATE SIGNED 3/19/84													
EXAMINER'S NAME (TYPE OR PRINT) K.S. AHLUNALIA				ADDRESS 2112 Dundalk Ave Balto. 21219																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 3/22/84		23c. NAME OF CEMETERY OR CREMATORY Westview				23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE Maryland											
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.										25a. DATE REC'D. BY REGISTRAR MAR 22 1984				25b. REGISTRAR'S SIGNATURE [Signature]							
ADDRESS 7922 Wise Avenue Dundalk, MD. 21222																					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Charles H. KINGERY					March 7, 1984					6:35 pm	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
male		white		Jan. 10, 1907		76		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Rossville			Franklin Sq. Hos.			guard			Pinkerton		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Md.			Balto.		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		37 Pikehall Place 21236		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
William Kingery					Bertha Lucas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
yes			1928		226-26-6730 Charles A. Kingery 37 Pikehall Pl.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrotising bronchopneumonia, bilateral 5130 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)						
			HOUR A.M. MONTH DAY YEAR P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 3, 1984</u> to <u>March 7, 1984</u> , that <input checked="" type="checkbox"/> (we) lost <u>March 7, 1984</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE					DEGREE					22c. DATE SIGNED	
<i>Allan Chircus M.D.</i>					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					3-7-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
Allan Chircus, M.D.					9000 Franklin Square Drive 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
cremation			3/8/84		Westview Mem. Pk.			Balto. Balto. Md.			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE	
Lassah FH.					7401 Belair Rd.					MAR 14 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
JESSIE CECILIA KIRCHNER			MARCH 18, 1984			7:23P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. YRS.		
FEMALE	WHITE	APRIL 24, 1893	90					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNSYLVANIA	USA		BALTIMORE, COUNTY			MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CATONSVILLE	ST. JOSEPH NURSING HOME		HOME MAKER					
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE		
MD.			BALTIMORE			3719 BEECH AVE. 21211		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
JOHN D. CAMERON			MARY WALSH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
NO			219-40-8788			MARGARET M. SIDES		
						40 ACORN CIRCLE APT. 302		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4292 Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>March 15, 1984</u> to <u>March 18, 1984</u> , that (I) (we) lost <u>about 11:00 AM</u> (did not) view the body after death.								
22b. SIGNATURE <u>Nelson J. McKay</u> M.D.						22c. DATE SIGNED <u>3/18/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NELSON J. MCKAY						22e. ADDRESS 1132 N. ROLLING RD. 21228		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 21, 1984			23c. NAME OF CEMETERY OR CREMATORY NEW ST. JOSEPH CEM.		
23d. LOCATION CITY OR TOWN COUNTY STATE LANCASTER LANCASTER PENNA.			23e. DATE REC'D. BY REGISTRAR MAR 20 1984			23f. REGISTRAR'S SIGNATURE <u>John Davidson</u>		
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME			24b. ADDRESS BALTIMORE, MD. 6500 YORK RD. 21212					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06369

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MIDDLE LAST Lena Ree KIVETT			MONTH DAY YEAR March 16, 1984			4:33am			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		CAU		MONTH DAY YEAR October 11, 1902		81 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina		USA				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rossville 21237		Franklin Square Hospital				Cafeteria Laborer		Food Co.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		Essex 21221		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1614 Rickenbacker Rd. 21221	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Marshal Eddinger				FIRST MIDDLE LAST Betty Conrad					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO				-		Betty Holtschneider 215 Antietam Rd 21221 (Daughter)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Massive Myocardial Infarction With Cardiopulmonary Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that X (this hospital) attended the deceased from March 15, 19 84, to March 16, 19 84, that X (we) last saw the deceased alive on March 16, 19 84, and that in X (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
Labib A. Labib, M.D.					M.D.			3-16-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Labib A. Labib, M.D.					9000 Franklin Square Drive 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			3/19/84		Oak Lawn cemetery		Baltimore Maryland		
24. FUNERAL DIRECTOR (PRINT NAME)					25a. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE		
Boudzinski Funeral Home					MAR 19 1984		Julia Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and submit to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

October 11, 1962

WFO

Dear Sir:

Re:

WFO 10-11-62

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM is being furnished to the Bureau for your information and for the Bureau's use in the event of a future investigation.

Very truly yours,

Special Agent in Charge

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. Pages 5 and 6 should be filed within 72 hours after death. Pages 7 and 8 should be filed within 72 hours after death. Pages 9 and 10 should be filed within 72 hours after death. Pages 11 and 12 should be filed within 72 hours after death. Pages 13 and 14 should be filed within 72 hours after death. Pages 15 and 16 should be filed within 72 hours after death. Pages 17 and 18 should be filed within 72 hours after death. Pages 19 and 20 should be filed within 72 hours after death. Pages 21 and 22 should be filed within 72 hours after death. Pages 23 and 24 should be filed within 72 hours after death. Pages 25 and 26 should be filed within 72 hours after death. Pages 27 and 28 should be filed within 72 hours after death. Pages 29 and 30 should be filed within 72 hours after death. Pages 31 and 32 should be filed within 72 hours after death. Pages 33 and 34 should be filed within 72 hours after death. Pages 35 and 36 should be filed within 72 hours after death. Pages 37 and 38 should be filed within 72 hours after death. Pages 39 and 40 should be filed within 72 hours after death. Pages 41 and 42 should be filed within 72 hours after death. Pages 43 and 44 should be filed within 72 hours after death. Pages 45 and 46 should be filed within 72 hours after death. Pages 47 and 48 should be filed within 72 hours after death. Pages 49 and 50 should be filed within 72 hours after death. Pages 51 and 52 should be filed within 72 hours after death. Pages 53 and 54 should be filed within 72 hours after death. Pages 55 and 56 should be filed within 72 hours after death. Pages 57 and 58 should be filed within 72 hours after death. Pages 59 and 60 should be filed within 72 hours after death. Pages 61 and 62 should be filed within 72 hours after death. Pages 63 and 64 should be filed within 72 hours after death. Pages 65 and 66 should be filed within 72 hours after death. Pages 67 and 68 should be filed within 72 hours after death. Pages 69 and 70 should be filed within 72 hours after death. Pages 71 and 72 should be filed within 72 hours after death. Pages 73 and 74 should be filed within 72 hours after death. Pages 75 and 76 should be filed within 72 hours after death. Pages 77 and 78 should be filed within 72 hours after death. Pages 79 and 80 should be filed within 72 hours after death. Pages 81 and 82 should be filed within 72 hours after death. Pages 83 and 84 should be filed within 72 hours after death. Pages 85 and 86 should be filed within 72 hours after death. Pages 87 and 88 should be filed within 72 hours after death. Pages 89 and 90 should be filed within 72 hours after death. Pages 91 and 92 should be filed within 72 hours after death. Pages 93 and 94 should be filed within 72 hours after death. Pages 95 and 96 should be filed within 72 hours after death. Pages 97 and 98 should be filed within 72 hours after death. Pages 99 and 100 should be filed within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
FIRST MIDDLE LAST OLGA M. KLINE					MONTH DAY YEAR HOUR 3 2 84 7 ⁰⁰ PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				
FEMALE		WHITE		MONTH DAY YEAR 10 7 24		59 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania		USA				Baltimore County MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Edgemere		2602 Manor Avenue				Housewife				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland			Baltimore		Edgemere		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2602 Manor Avenue 21219	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Steven Gaydos					FIRST MIDDLE LAST Mary Horton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No			220-14-9469		Paul W. Kline, Sr.		Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Mitotic Adenocarcinoma to both pleura,</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) <i>primary unknown</i>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>s/p Colon resection for colon cancer</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from August 8, 1983, to February 14, 1984, that (1) (we) last saw the deceased alive on Feb. 14, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
Chi-Shiang Chen					MD			3-3-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
CHI-SHIANG CHEN					100 N. BROADWAY BALTIMORE MD 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial			3/6/1984		Sacred Ht. Of Jesus Dundalk Balto.			Maryland		
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME Duda-Ruck, Inc.					MAR 6 1984		J. Anderson-Randall			
7922 Wise Avenue Dundalk, MD. 21222										

BP

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK J. KLINGLER			2a. DATE OF DEATH MONTH DAY YEAR March 5, 1984		2b. HOUR 7:33 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 15, 1887		
6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Switzerland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2009 Hallsby Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
12b. KIND OF BUSINESS OR INDUSTRY Butcher						
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2009 Helmsby Road 21228				
4. FATHER'S NAME FIRST MIDDLE LAST Jacob Klingler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Andarau			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 291-05-0134		17. INFORMANT Mrs. Erma Simons		
				ADDRESS Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HASCVD 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Urinary tract infection DUE TO, OR AS A CONSEQUENCE OF (c) Peripheral vascular disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 2 months 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) None						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) did XXXXXX attended the deceased from 16 July , 19 71 , to 5 March , 19 84 , that (I) was XX saw the deceased alive on 23 January , 19 84 , and that in (my) own XX opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Wilmar Gallagher M.D.				22c. DATE SIGNED 6 March 84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilmar Gallagher M.D.				22e. ADDRESS St. Agnas Medical Building, Baltimore, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/9/84		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Massillon Ohio						
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A.				25a. DATE REC'D. BY REGISTRAR MAR 8 1984		
25b. REGISTRAR'S SIGNATURE L. Witzke						
26. ADDRESS 1630 Edmondson Avenue, Catonsville, Md. 21228						

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

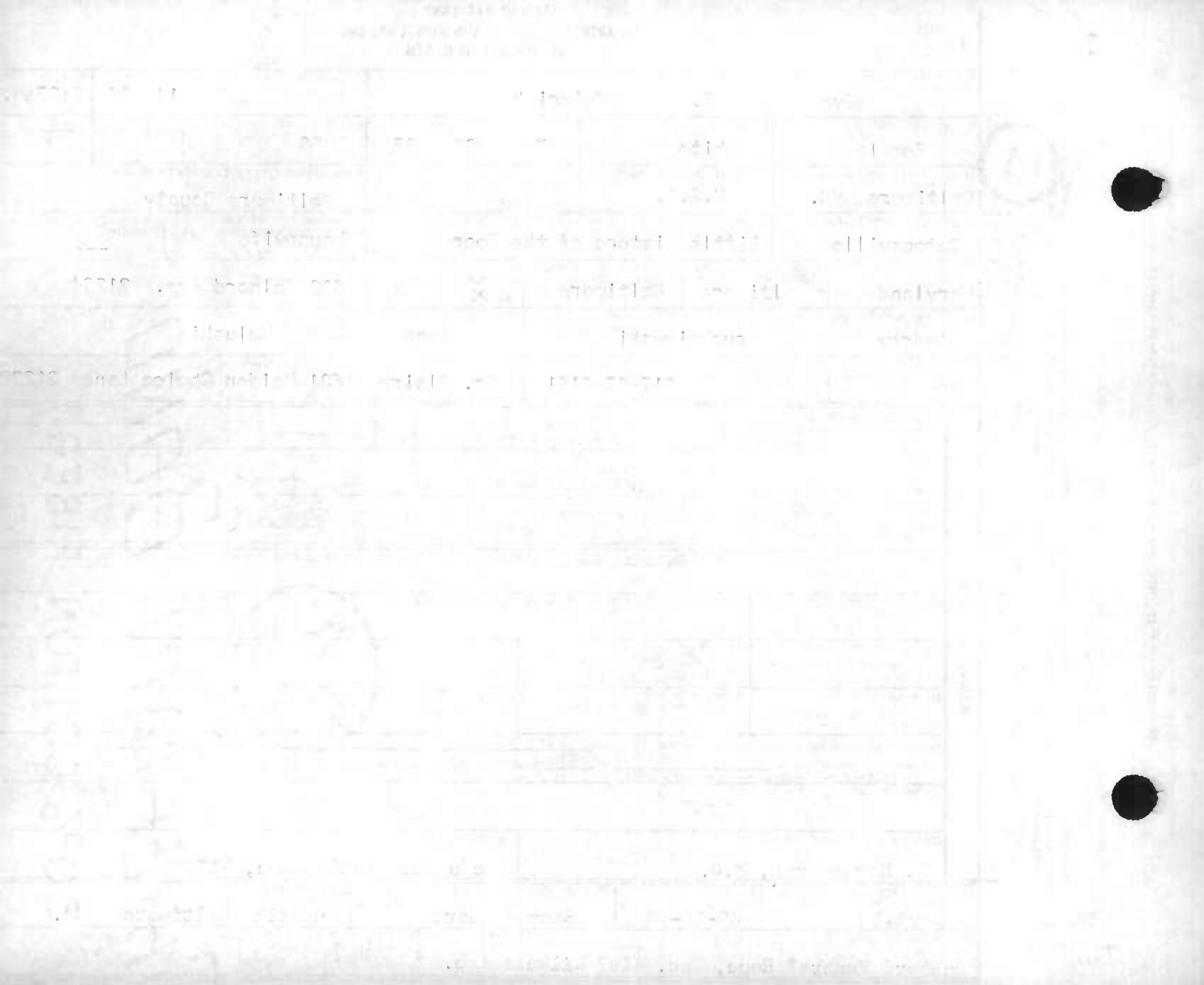
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06372

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eva P. Kmieclak			2a. DATE OF DEATH MONTH DAY YEAR 3 14 84			2b. HOUR 6:27am.	
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 28 95		6. AGE (IN YEARS LAST BIRTHDAY) 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Little Sisters of the Poor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	
12b. KIND OF BUSINESS OR INDUSTRY ---		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13c. CITY OR TOWN Baltimore					
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 609 Belthord Ave. 21224					
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Pruchniewski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Maluski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-07-6151		17. INFORMANT ADDRESS Sr. Claire 601 Malden Choice Lane 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>1749</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic disease from</u> (c) <u>Carcinoma of Breast</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:27 P.M. 3 14 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if (this hospital) attended the deceased from <u>4/25</u> , 19 <u>78</u> , to <u>3/14</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>3/11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. Ravendhran, M.D.				22e. ADDRESS c/o St. Martin Home, 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 03-16-84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR MAR 16 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06373

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edna R. Knapp			2a. DATE OF DEATH MONTH DAY YEAR March 30, 1984			2b. HOUR 3²⁰ P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR July 23, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co., MD.			
10. CITY OR TOWN OF DEATH Owings Mills, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baptist Home of Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5 Seminole Ave. 21228	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Wicks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 22 6957		17. INFORMANT ADDRESS Mrs. Thelma K. Bossle Ocean City, Md. 21842				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONITIS, POSSIBLY VIRAL CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST 10 DAYS 2 weeks								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a NONE									
19a. DATE OF OPERATION ---			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ---				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ---		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ---				
22a. I certify that (I) (the hospital) attended the deceased from JULY 19 82 to MARCH 19 84 , that (I) (we) last saw the deceased alive on 3-29 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE John G. Lavin, MD DEGREE MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-2-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. LAVIN, MD				22e. ADDRESS 6805 YORK RD, BART. MD 21212					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/2/84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.		23d. LOCATION (CITY OR TOWN) COUNTY STATE Timonium, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.					25a. DATE REC'D. BY REGISTRAR APR 3 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randell		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
JAN 10 1964

10

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or letter body with several paragraphs of text that is mostly illegible due to fading and bleed-through.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) THELMA H. KNIGHT					2a. DATE OF DEATH MONTH 3 DAY 20 YEAR 84				2b. HOUR 6:17 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH July DAY 27 YEAR 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 2 YRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Presser		12b. KIND OF BUSINESS OR INDUSTRY Clothing			
13a. STATE md.		13b. COUNTY BALTO.		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2117 515 PLEASANT HILL RD			
14. FATHER'S NAME FIRST Henry MIDDLE Hellmig LAST Hellmig					15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Wagner LAST Wagner					ADDRESS 515 Pleasant Hill Rd Owings Mills, Md	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no.					16b. SOCIAL SECURITY NO. 216-05-8578		17. INFORMANT Louis J. Knight				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteriosclerotic heart disease with 4140 DUE TO, OR AS A CONSEQUENCE OF Pulmonary edema (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Hypertension											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b. TIME OF INJURY HOUR 3 A.M. MONTH 12 DAY 19 P.M. YEAR 84			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-20-84 to 3-20-84 , that (I) (we) last saw the deceased alive on 3-20-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Soon Chul Hong					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-20-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOON CHUL HONG					22e. ADDRESS Baltimore County General Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 23, 1984		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d. LOCATION CITY OR TOWN Pikesville COUNTY Balto. STATE md.				
24. FUNERAL DIRECTOR NAME H. J. Eichhardt ADDRESS Owings Mills, Md					DATE OF RECORD BY REGISTRAR MAR 23 1984						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Paul V. Knox			2a. DATE OF DEATH MONTH DAY YEAR March 24, 1984		2b. HOUR M	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4-20-13		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD.		
10. CITY OR TOWN OF DEATH Balto	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1738 Wentworth Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur Ret.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1738 Wentworth Rd. 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Charles F. Knox			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Belle McCauley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-12-7262		17. INFORMANT ADDRESS Frances A. Knox, Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE LUNG DISEASE 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF THE LUNG 8 YRS DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY TUBERCULOSIS 12 YRS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (i) (this hospital) attended the deceased from MAR 9, 19 84, to MAR 24, 19 84, that (ii) (we) last saw the deceased alive on MAR 24, 19 84, and that in (iii) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Richard W. Bittrick M.D.				DEGREE M.D.		22c. DATE SIGNED MAR 24, 1984
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard W. Bittrick, M.D.				22e. ADDRESS 8100 Harford Road Baltimore, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-27-84	23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 27 1984		
				25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				706375			
1. DECEASED NAME (TYPE OR PRINT) Martin V. Korsch				2a. DATE OF DEATH MONTH DAY YEAR 3 8 84			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 8 97		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czech.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastpoint Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY GLENN L. MARTIN	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ferdinand Korsch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Simek		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 217-09-8012		17. INFORMANT ADDRESS GLORIA SCHALLER (DGHTR) ARNOLD, MD, 21012					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac Death 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD, CHF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-6, 19 84, to 3-8, 19 84, that (I) (we) last saw the deceased alive on 3-8-84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. B. Little M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-8-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 1012 Old North Point Rd Balto Md 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/10/84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR MAR 12 1984			
25b. REGISTRAR'S SIGNATURE John Davidson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR		LILLIAN M. KOUTEK		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		06371	
Item #6 Film #G590 4/5/84		CERTIFICATE OF DEATH		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Lillian Koutek				2a. DATE OF DEATH MONTH DAY YEAR 3 27 84		2b. HOUR M			
3 SEX Female		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 05 31 02		6. AGE (IN YEARS LAST BIRTHDAY) 82 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY		MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS) PERRING PARKWAY NURSING HOME		12a. USUAL OCCUPATION (GIVE OR WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 811 N. CURLEY ST. 21205			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH UHLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST -----		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213097517		17. INFORMANT ADDRESS STANLEY KOUTEK 8710 ASHFORD RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Embolism 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Advanced arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy - infarcted				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gracie K. Patricia		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/27/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gracie K. Patricia		22e. ADDRESS Perring Parkway Nursing Home 21234							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/30/84		23c. NAME OF CEMETERY OR CREMATORY BOHEMIAN NATL.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. --- MD.			
24. FUNERAL DIRECTOR (NAME) John		ADDRESS 1211 Chesapeake Ave.		25a. DATE REC'D. BY REGISTRAR MAR 29 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

UNITED STATES GOVERNMENT
OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301
MEMORANDUM FOR THE SECRETARY OF DEFENSE
SUBJECT: [Illegible]
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06378

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Kathleen M. Kriete		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
February 4 1912		72 YRS.		Baltimore County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Virginia		U.S.A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Randallstown		Baltimore County General Hospital		Home Maker	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Baltimore		Catonsville	
4. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS	
Russell Jay Smedley		Mary Leach		803 Woodsdale Road	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		213-05-7689		Howard Kriete	
				803 Woodsdale Road	
				Catonsville Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Diabetes mellitus with infected</i>					
DUE TO, OR AS A CONSEQUENCE OF <i>gangrene</i>					
(b) <i>Occlusion of aorto-femoral bypass</i>					
DUE TO, OR AS A CONSEQUENCE OF <i>Cerebrovascular accident</i>					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
<i>Arteriosclerotic Cardiovascular disease</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3-22-19-84</i> to <i>3-29-19-84</i> that (I) (we) lost saw the deceased alive on <i>3-29-19-84</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>Soonchal HONG</i>				<i>3-29-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<i>SOONCHAL HONG</i>		<i>Baltimore County General Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		04/02/84		Granite Presbyterian	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
Granite		Baltimore		Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME Loring Byers Funeral Directors, Inc.		APR 3 1984		<i>John Davidson-Randall</i>	
ADDRESS 8728 Liberty Road Randallstown, Maryland 21133					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) WILLIAM MAURICE KRONEBERGER					2a. DATE OF DEATH MONTH DAY YEAR MARCH 6, 1984			2b. HOUR 1:00 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 300 Ingleaside Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool & Die Maker		12b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Maurice Kroneberger					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence M. Workmeister					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-05-5353		17. INFORMANT ADDRESS M. Virginia Kroneberger Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE PROSTATE WITH WIDESPREAD METASTASIS 1850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 4 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>we</u> <u>hospital</u> attended the deceased from <u>9/12</u> , 19 <u>79</u> , to <u>3/6</u> , 19 <u>84</u> , that (I) <u>we</u> last saw the deceased alive on <u>11/27</u> , 19 <u>83</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>not</u> view the body after death.										
22b. SIGNATURE E. Kasaitis M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Kasaitis M.D.			22e. ADDRESS 1801 FRESHWATER RD BALTIMORE, MD 21228							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/9/84		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Lord & Russell C. Witzke Funeral Homes P.A. ADDRESS 1630 Edmondson Avenue, Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR MAR 8 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 6 3 3 0

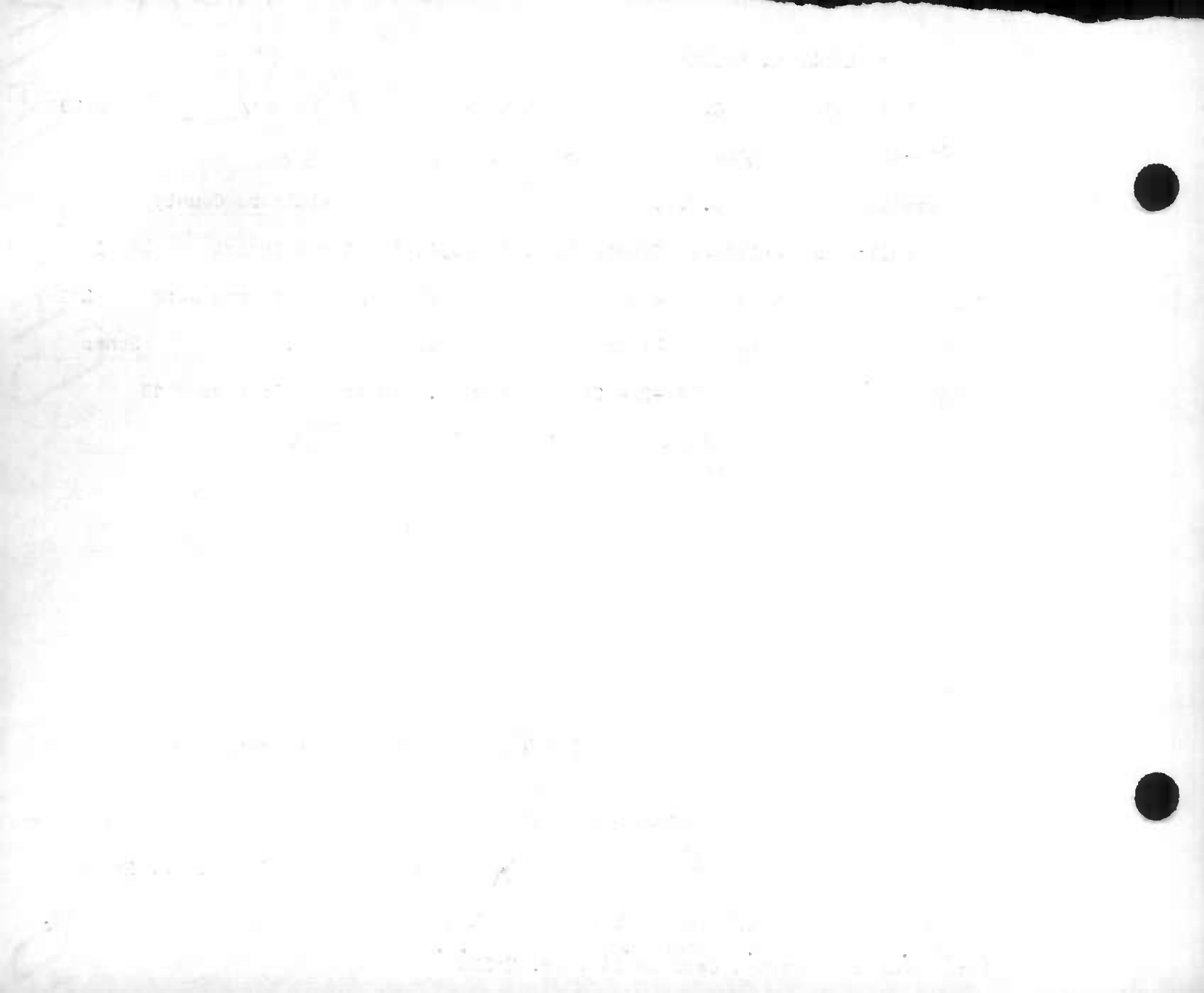
FOR
1 - STATE
REGISTRAR

LEOLA C. KRUGER

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEOLA C. KRUGER			2a. DATE OF DEATH MONTH DAY YEAR 3-9-84		2b. HOUR 8:28P M
1. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3-10-23		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Typist	12b. KIND OF BUSINESS OR INDUSTRY Steel	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Woodlawn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Leo F. Dietz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada T. Jones		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-20-6267		17. INFORMANT ADDRESS Paul W. Kruger Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c) CAD Post M.I.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-9, 1984, to 3-9, 1984, that (I) (we) lost saw the deceased alive on 3-9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Wenifredo Iglesias				DEGREE M.D.	22c. DATE SIGNED 3-9-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WENIFREDO N. IGLESIA				22e. ADDRESS BCRH, Randallstown, Md. 21133	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/13/84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	
23d. LOCATION CITY OR TOWN Woodlawn		23e. COUNTY Md.		23f. STATE Md.	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228				25. DATE REC'D. BY REGISTRAR MAR 13 1984	
26. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06381	
1. DECEASED NAME (TYPE OR PRINT) GERALDINE Jayne KURAPKA							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR 3-8-84		2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 20, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 3-8-84 19 3:45	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) York Rd. Westbound ramp at #695				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Health Dept		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 505 Academy Road 21228			
14. FATHER'S NAME FIRST MIDDLE LAST Henry C. Jayne Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Virginia King					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS 36 Overbrook Rd. Balto., Md. 21228					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral injuries 8121 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:30PM 3-8-84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) passenger of an auto/tractor trailer impact					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy. York		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rd. Westbound ramp at 695 Balto. Co. Md.					
22a. I certify that I took charge of the remains described above. Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell						TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 3-9-84		
EXAMINER'S NAME (TYPE OR PRINT) MARGARITA A. Korell, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/12/84		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville, Md.						25a. DATE REC'D. BY REGISTRAR MAR 13 1984		25b. REGISTRAR'S SIGNATURE Julia Pavlikova-Randell			

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Handwritten signature



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. per F.H. 3/27/84 kam									
1- STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) John D Lacon LaCon					2a. DATE OF DEATH MONTH DAY YEAR 3-20-84		2b. HOUR 7:34pm		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 5, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore county MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET AND NO.) St Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lieutenant		12b. KIND OF BUSINESS OR INDUSTRY Fire Dept.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 206 One Smeton Place - 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph LaCon					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Marino				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-46-9219		17. INFORMANT ADDRESS Frances A. LaCon Same				
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Chronic Coronary Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Recent Coronary Thrombosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>YES</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Bypass 3.12.84</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>3-19-84</i> to <i>3-20-84</i> , that (I) (we) last saw the deceased alive on <i>3-19-84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)									
22b. SIGNATURE <i>Francis V. Daly</i>					DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3.20.84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Francis Daly, M.D.					22e. ADDRESS 7620 York Road towson Md 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Mar. 21, 1984		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212					25a. DATE REC'D. BY REGISTRAR MAR 23 1984				
25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/B2

FOR THOMAS J. LACOTTI		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		06383		REG. NO.	
1- STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)		FIRST THOMAS		MIDDLE J		LAST LACOTTI		2a. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19	
3. SEX MALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 08 10 38		6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR MAR 25 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COMMUNICATIONS		12b. KIND OF BUSINESS OR INDUSTRY POLICE	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. CITY BALTIMORE		13c. CITY OR TOWN ROSEDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 303 PATAPSCO AVE. 21237	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS LACOTTI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE KOTWALD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 219267111		17. INFORMANT ADDRESS BEVERLY LACOTTI 303 PATAPSCO AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Paul F. Guerin		TITLE (SPECIFY) DEPUTY		M.D. DEPUTY		MEDICAL EXAMINER		DATE SIGNED 3/26/84	
EXAMINER'S NAME (TYPE OR PRINT) PAUL F. GUERIN		ADDRESS 1311 WESTERN RUN RD COCKEYSVILLE MD 21030							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/29/84		23c. NAME OF CEMETERY OR CREMATORY GRADENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MD.			
24. FUNERAL DIRECTOR NAME John						25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE John Davidson	

CONFIDENTIAL

1. [illegible] 2. [illegible]

3. [illegible] 4. [illegible] 5. [illegible]

6. [illegible] 7. [illegible] 8. [illegible]

9. [illegible] 10. [illegible] 11. [illegible]

12. [illegible] 13. [illegible] 14. [illegible]

15. [illegible] 16. [illegible] 17. [illegible]

18. [illegible] 19. [illegible] 20. [illegible]

21. [illegible] 22. [illegible] 23. [illegible]

24. [illegible] 25. [illegible]

26. [illegible] 27. [illegible] 28. [illegible]

29. [illegible] 30. [illegible] 31. [illegible]

32. [illegible] 33. [illegible] 34. [illegible]

35. [illegible] 36. [illegible] 37. [illegible]

38. [illegible] 39. [illegible] 40. [illegible]

41. [illegible] 42. [illegible] 43. [illegible]

44. [illegible] 45. [illegible] 46. [illegible]

47. [illegible] 48. [illegible] 49. [illegible]

50. [illegible] 51. [illegible] 52. [illegible]

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP _____

DHMH - 16 50M 4/B3
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST (Ester) MIDDLE (Marconi) LAST (LAFORTEZZA) Ethel Gates LAFORTEZZA						2a. DATE OF DEATH MONTH DAY YEAR March 2, 1984			2b. HOUR 9:00A M		
3. SEX Females		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar 16, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3206 Mayfair Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. STATE Maryland						13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3206 Mayfair Road 21207											
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julie Tote Gates					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-30-6376		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <i>Arteriosclerotic cardiac vas. disease</i> 4292 DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/23</i> 19 <i>80</i> , to <i>3/2</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>12/12</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Irvin Kaplan</i>						22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>3/5/84</i>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Irvin Kaplan						22g. ADDRESS 129 S. Broadway Baltimore MD 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Lakeview Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Maryland				
24. FUNERAL DIRECTOR Dippel Funeral Homes						7110 Belair Rd. Balto MD 21206		25a. DATE REC'D. BY REGISTRAR MAR 5 1984		25b. REGISTRAR'S SIGNATURE <i>F. Davidson</i>	

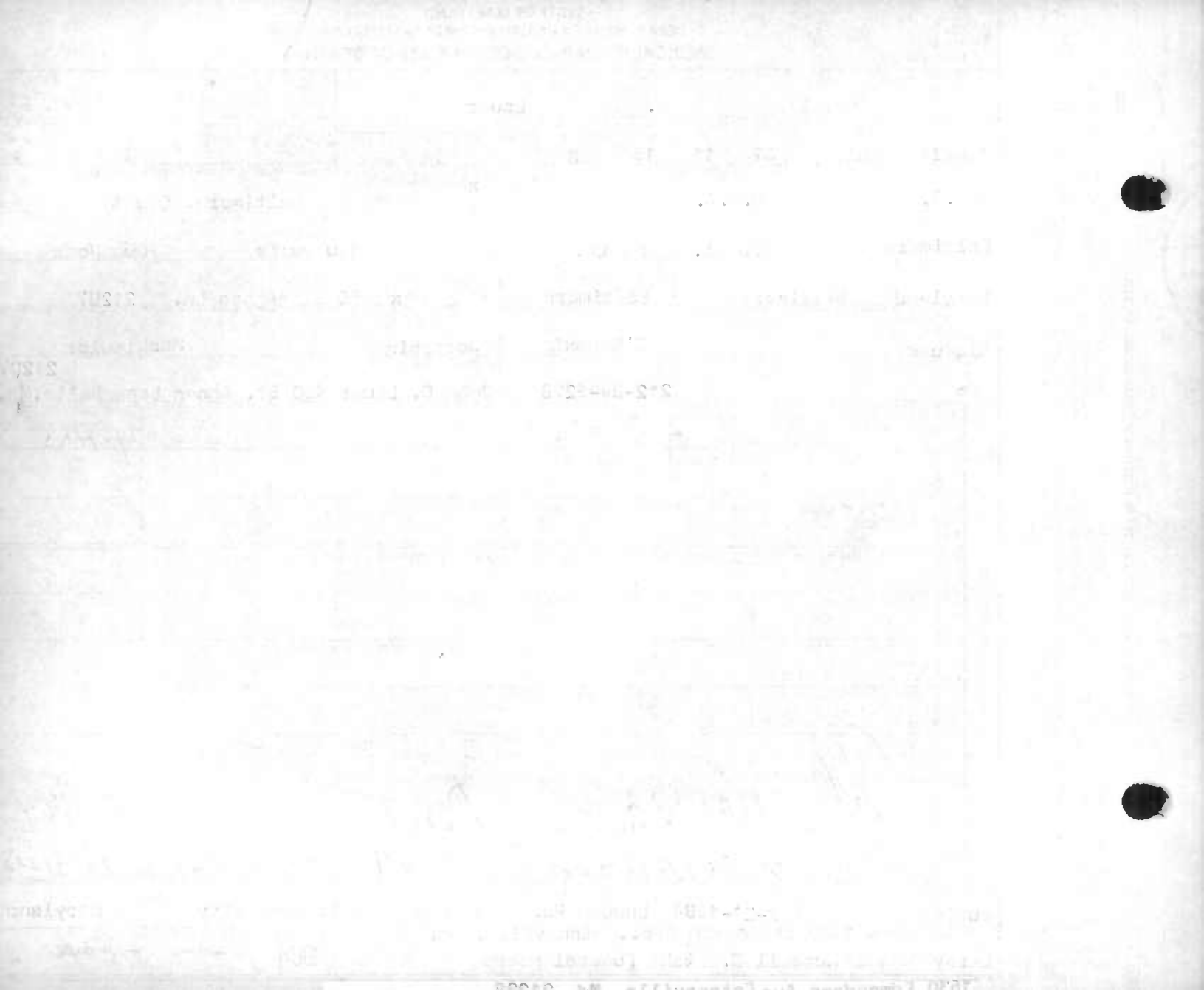


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Estelle E. Lauer						2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		2b. HOUR		2c. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		2d. HOUR	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 07 DAY 11 YEAR 15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 24 HRS. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD MONTH 2 DAY 18 YEAR 1984		7d. HOUR 8:48 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, County MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 950 St. Agnes Ln.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 950 St. Agnes Ln. 21207			
14. FATHER'S NAME FIRST Sigmund MIDDLE O' LAST Konski						15. MOTHER'S MAIDEN NAME FIRST Josephine MIDDLE Mackiewicz LAST Mackiewicz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-09-6278		17. INFORMANT John C. Lauer				ADDRESS 950 St. Agnes Lane Balto. Md. 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 49 HRS													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) Deputy				DATE SIGNED 3/1/84					
EXAMINER'S NAME (TYPE OR PRINT) E.P. WILLIAMS JR.				ADDRESS 5550 BRADDOCK NAT'L PK 21228									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-21-1984		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland					
24. FUNERAL DIRECTOR NAME Leroy M. and Russell C. Witzke Funeral Homes ADDRESS 1630 Edmondson Ave., Catonsville, Md.						DATE REC'D. BY REGISTRAR MAR 20 1984		25b. REGISTRAR'S SIGNATURE [Signature]					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06386

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Josie Le Croy			2a. DATE OF DEATH MONTH DAY YEAR March 8, 1984		2b. HOUR M
3. SEX Female	4. RACE CAU	5. DATE OF BIRTH MONTH DAY YEAR June 15, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Middle River	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7 East Midland Road 21220			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Middle River	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Dan Duff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Shorter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212 34 5525		17. INFORMANT ADDRESS Aubra Allen same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Severe atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Severe Rhyphoscoliosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Malnutrition, Chronic airway obstruction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from August 30, 1983 , to February 23, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I we) did not view the body after death.					
22b. SIGNATURE M. J. Sheridan		DEGREE		22c. DATE SIGNED 3/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN J. SHERIDAN		22e. ADDRESS 9000 Franklin Square Drive, Baltimore Md 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-12-84		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County Maryland		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home		24a. ADDRESS Pa 1407 Old Eastern Ave		25. REGISTRAR'S SIGNATURE Mar 9 1984	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 18.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) YUSUF LEHAR					2a. DATE OF DEATH MONTH DAY YEAR March 26, 1984		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 21, 1978		2b. HOUR 11:45 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 5 YRS.		8. UNDER 1 YEAR MONTHS DAYS	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3201 NORTHWIND ROAD		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		12b. KIND OF BUSINESS OR INDUSTRY	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MOHAMED LEHAR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOYCE LYNN BARTHLOW					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MOTHER (MRS. JOYCE O'DWYER)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 7599 DUE TO, OR AS A CONSEQUENCE OF (b) chronic respiratory disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) congenital anatomical malformations APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) acute gastroenteritis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from July 1982 to March 26, 1984 , that (I) was lost saw the deceased alive on March 16, 1984 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.							
22b. SIGNATURE Michael B. Stewart, M.D.				DEGREE M.D.		22c. DATE SIGNED March 26, 1984	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL B. STEWART, M.D.				23b. ADDRESS 2850 N. Charles St., Balto, Md. 21218			
23c. BURIAL, CREMATION, REMOVAL (SPECIFY)		23d. DATE 3-27-84		23e. NAME OF CEMETERY OR CREMATORY Dulaney Valley M.G.		23f. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME LASSAHN F.H. 7401 A.R. Balto. Md.				25a. DATE REC'D. BY REGISTRAR MAR 29 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP



LIBER

11/11/11

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frederick Deal Leonard			2a. DATE OF DEATH MONTH DAY YEAR March 4, 1984			2b. HOUR 8:20p.m.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 15, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rail Road Inspector Southern			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John White Leonard			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Deal			16. STREET ADDRESS / ZIP CODE 3902 Tila Road 21234			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 704-14-7619		17. INFORMANT ADDRESS Mrs. Mary Ann Eck 3902 Tila Road 21234				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ac. myocardial infarction</i> <i>4100</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>coronary artery dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb. 25</i> 19 <i>84</i> to <i>March</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>Feb. 25</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert Roubenoff</i>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>3.5.1984</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Roubenoff			22e. ADDRESS 7652-A Belair Road						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 13, 1984		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland		
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 211334784					25a. DATE REC'D. BY REGISTRAR MAR 6 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 through 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

ADAMS

LIBEL



COPIES

100%



MAR 6 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or retained.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) AKA FIRST ALBERT MIDDLE E. LAST LEWIS ALBERT H. LEWIS				2a. DATE OF DEATH MONTH DAY YEAR 03 07 84 2b. HOUR 12:30A ^M			
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 31 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH ARBUTUS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 903 JOH AVENUE, 21229		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN ARBUTUS		13e. STREET ADDRESS / ZIP CODE 903 JOH AVENUE, 21229	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN LEWIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ALFORD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW I 290-07-8450		17. INFORMANT ADDRESS FRANCES WOODBURN 903 JOH AVENUE, 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (c) Sudden Aortic Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/11 1979 to 3/7 1984, that (I) (we) lost saw the deceased alive on 2/4 1984, and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23. SIGNATURE (Signature) DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				23b. DATE SIGNED 3/8/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN C. HEALY, M.D.				22e. ADDRESS 1311 FRANCIS AVENUE, 21227			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 03-10-84		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 9 1984 Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					06390						
1. DECEASED NAME (TYPE OR PRINT) Phil PHIL MIDDLE LI LAST Li					2a. DATE OF DEATH MONTH 3 DAY 14 YEAR 84			2b. HOUR 845 AM			
3. SEX MALE		4. RACE ORIENTAL		5. DATE OF BIRTH MONTH October DAY 20 YEAR 1920		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-City Editor			12b. KIND OF BUSINESS OR INDUSTRY A.S. Abell, Co.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Phoenix		13e. STREET ADDRESS / ZIP CODE 3612 Golden Eagle Dr.-21131					
14. FATHER'S NAME FIRST Chi MIDDLE Luk LAST Liv					15. MOTHER'S MAIDEN NAME FIRST Wai MIDDLE Foon LAST Poon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 073-26-7057		17. INFORMANT ADDRESS Jane Li - Same as #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: Cardiopulmonary arrest IMMEDIATE CAUSE (a) 0114 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) Old Tuberculosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 3 , 19 84 , to March 14 , 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 14 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE Fred Dresser						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/14/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRED DRESSER						22e. ADDRESS FRANKLIN SQUARE HOSP.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3-19-84		23c. NAME OF CEMETERY OR CREMATORY Westview			23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204			25a. DATE REC'D. BY REGISTRAR MAR 16 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06391

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES Craig LINDEMONT			2a. DATE OF DEATH MONTH DAY YEAR 3/23/84			2b. HOUR 2:15 AM	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Sept. 9, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail Sales	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Lindemon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hellen Marshall Craig			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 217 26 3434A		17. INFORMANT ADDRESS Mrs. Emma H. Lindemon 1506 E. Joppa Road			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C.V.D. and</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pul. Dis.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>C.I. Bleed</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I (this hospital) attended the deceased from <u>3/19</u> 19 <u>84</u> , to <u>3/23</u> 19 <u>84</u> , that (we) lost saw the deceased alive on <u>3/23</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death).					
22b. SIGNATURE <u>Lester A. Wall, Jr.</u>		DEGREE MD		22c. DATE SIGNED 3/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LESTER A. WALL, JR.		22e. ADDRESS 7620 York Rd Towson Md 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/23/84		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.				25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Lindemon Randall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Helen Mary Livermon						2a. DATE OF DEATH MONTH DAY YEAR March 26, 1984			2b. HOUR 1:30a M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 15 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9401 Franklin Square Dr. 21237			
14. FATHER'S NAME FIRST MIDDLE LAST Frank M. Farrar				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolina Kolletch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 212-26-1641		17. INFORMANT ADDRESS Geo. Pilker (son) same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5860 IMMEDIATE CAUSE (a) Cardiac Arrest, Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from March 19 , 19 84 , to March 26 , 19 84 , that (we) lost saw the deceased alive on March 26 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death.											
22b. SIGNATURE <i>W. Kazimierzczak</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 03/26/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Kazimierzczak, M.D.						22e. ADDRESS 9000 Franklin Sq. Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/29/84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR Schimmunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randell</i>			

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1917



ARMY'S RAM

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LYDIA J. LOVE			2a. DATE OF DEATH MONTH DAY YEAR 3 13 84		2b. HOUR 10 ¹¹ A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 17, 1889		
6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		8. CITIZEN OF WHAT COUNTRY? USA		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		10. CITIZEN OF WHAT COUNTRY? USA		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
12. CITY OR TOWN OF DEATH Lutherville		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) College Manor Nursing Home		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Wash. D.C.		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS / ZIP CODE Farnsbarr Apts. 99999		
18. FATHER'S NAME FIRST MIDDLE LAST Rodney Janney		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Jackson		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
21. SOCIAL SECURITY NO. 577 05 7680		22. INFORMANT Mrs. Beverly C. Compton, Balto., MD		23. ADDRESS		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>heart failure</u> 4289 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED		25c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
27a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27c. LOCATION CITY OR TOWN COUNTY STATE		
28a. I certify that (1) (the hospital) attended the deceased from <u>10</u> , 19 <u>80</u> , to <u>3/13</u> , 19 <u>84</u> , that (we) last saw the deceased alive on <u>3/13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (did not) view the body after death.						
29a. SIGNATURE <u>Carl Friedman</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				29b. DATE SIGNED 3/13/84		
30a. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Carl Friedman, M.D.				30b. ADDRESS 660 Kenilworth Dr., Balto., MD		
31a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		31b. DATE 3/14/84		31c. NAME OF CEMETERY OR CREMATORY Green Mount		
32a. LOCATION CITY OR TOWN Balto.,		32b. COUNTY MD		32c. STATE		
33. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212				34. DATE REC'D. BY REGISTRAR MAR 14 1984		
35. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>						

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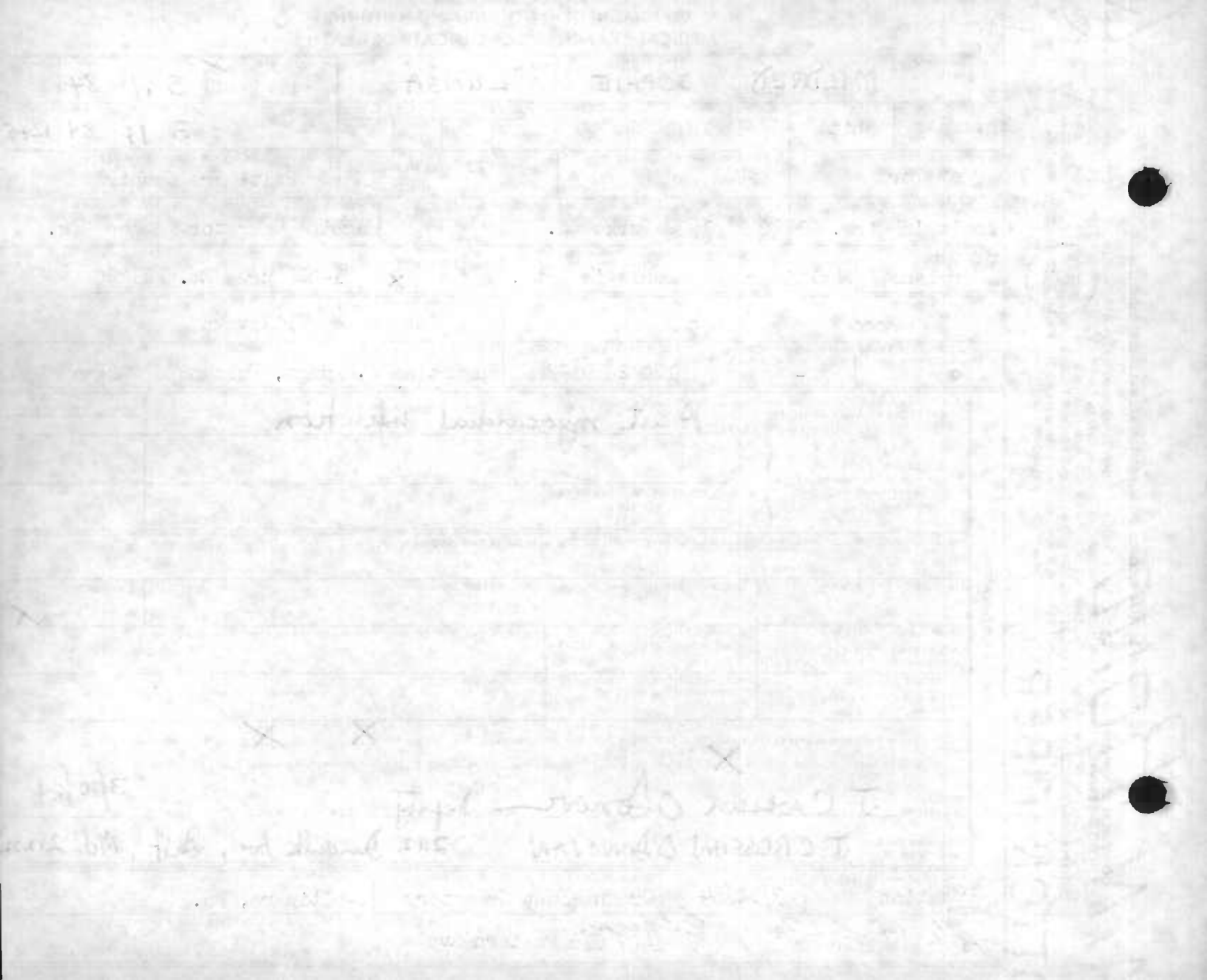
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MILDRED SOPHIE LUNGA		LAST		6a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 3 YEAR 10 19 84		7b. HOUR									
8. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH April DAY 18 YEAR 1928		6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS.		IF UNDER 1 YR. MONTHS 55 DAYS 55		IF UNDER 24 HRS. HOURS 55 MIN. 55		7c. DATE PRONOUNCED DEAD MONTH 3 DAY 14 YEAR 19 84		7d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		MD							
10. CITY OR TOWN OF DEATH Bowley's Qtrs. 21220		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1432 Burke Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Shoe Mfg.									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Bowley's Qtrs.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1432 Burke Rd. 21220							
14. FATHER'S NAME FIRST Jerry MIDDLE Konecny LAST 		15. MOTHER'S MAIDEN NAME FIRST Josephine MIDDLE Prikavska LAST 													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 120 20 9192		17. INFORMANT Augustine J. Lunga, Husband		ADDRESS Same									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 Acute myocardial infarction IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE J. Crossan O'Donovan		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 3/10/84									
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN		ADDRESS 2112 Dundalk Ave., Balt., Md. 21220													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/12/84		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN Baltimore, Md. COUNTY STATE									
24. FUNERAL DIRECTOR Dzudzinski Funeral Home		ADDRESS 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR MAR 10 1984		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall									



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John T. LYNCH			2a. DATE OF DEATH MONTH DAY YEAR March 9, 1984			2b. HOUR 2:35a M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 31 1925		6. AGE (IN YEARS LAST BIRTHDAY) 58		7. IF UNDER 1 YEAR MONTHS DAYS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Carrier		12b. KIND OF BUSINESS OR INDUSTRY U. S. Gov'n't	
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 2111 Watervale Ave. 21047			14. FATHER'S NAME FIRST MIDDLE LAST John D. Lynch			15. MOTHER'S MAIDEN NAME FIRST LAST Mary Terry			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW 11 219-14-1365		17. INFORMANT ADDRESS 2111 Watervale Ave. Fallston, Md. 21047				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 0389 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Septicemia, Upper Gastrointestinal Bleeding, Liver Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he) (this hospital) attended the deceased from February 22, 1984 to March 9, 1984 , that (he) (we) last saw the deceased alive on March 9, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.									
22b. SIGNATURE I. Rodriguez					DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 03/09/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) I. Rodriguez, M.D.					22e. ADDRESS 9000 Franklin Sq. Dr., 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-12-1984		23c. NAME OF CEMETERY OR CREMATORY St. Johns R. Cath. Cem.		23d. LOCATION Long Green Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS E.F. Lassam, 11750 Belair Rd. Kingsville, Md. 21088					25a. DATE REC'D. BY REGISTRAR MAR 16 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1. The first part of the document is a list of names and addresses, including:

 John Smith, 123 Main Street, New York, N.Y.

 Mary Jones, 456 Elm Street, Boston, Mass.

 Robert Brown, 789 Oak Street, Chicago, Ill.

 The second part of the document is a list of dates and times, including:

 January 1, 1950, 10:00 AM

 February 1, 1950, 11:00 AM

 March 1, 1950, 12:00 PM

 The third part of the document is a list of names and addresses, including:

 John Smith, 123 Main Street, New York, N.Y.

 Mary Jones, 456 Elm Street, Boston, Mass.

 Robert Brown, 789 Oak Street, Chicago, Ill.

 The fourth part of the document is a list of dates and times, including:

 January 1, 1950, 10:00 AM

 February 1, 1950, 11:00 AM

 March 1, 1950, 12:00 PM

 The fifth part of the document is a list of names and addresses, including:

 John Smith, 123 Main Street, New York, N.Y.

 Mary Jones, 456 Elm Street, Boston, Mass.

 Robert Brown, 789 Oak Street, Chicago, Ill.

 The sixth part of the document is a list of dates and times, including:

 January 1, 1950, 10:00 AM

 February 1, 1950, 11:00 AM

 March 1, 1950, 12:00 PM

 The seventh part of the document is a list of names and addresses, including:

 John Smith, 123 Main Street, New York, N.Y.

 Mary Jones, 456 Elm Street, Boston, Mass.

 Robert Brown, 789 Oak Street, Chicago, Ill.

 The eighth part of the document is a list of dates and times, including:

 January 1, 1950, 10:00 AM

 February 1, 1950, 11:00 AM

 March 1, 1950, 12:00 PM

 The ninth part of the document is a list of names and addresses, including:

 John Smith, 123 Main Street, New York, N.Y.

 Mary Jones, 456 Elm Street, Boston, Mass.

 Robert Brown, 789 Oak Street, Chicago, Ill.

 The tenth part of the document is a list of dates and times, including:

 January 1, 1950, 10:00 AM

 February 1, 1950, 11:00 AM

 March 1, 1950, 12:00 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RODERICK A. MACFAYDEN						03 18 84						3:15A	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 5 04		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.							
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INST. (GBMC) (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 NORTH CHARLES STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor Maint.				12b. KIND OF BUSINESS OR INDUSTRY Electric Energy			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10856 Sandringham Rd. #21030					
14. FATHER'S NAME FIRST MIDDLE LAST Daniel MacFayden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora MacIntosh				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 065-07-8821				17. INFORMANT Mr. Kenneth J. MacFadyen				ADDRESS Cockeysville, Md. ham Rd. #21030					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) METASTATIC LUNG CARCINOMA													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 03-18 03-09-19 84 to 03 18 19 84, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert A. Palermo MD				DEGREE ASSOCIATE PATHOLOGIST				DATE SIGNED 03-18-84					
22c. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT A PALERMO MD				22d. ADDRESS 6701 NORTH CHARLES STREET (GBMC)									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 3/20 /84		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. Co., Md.					
24. FUNERAL DIRECTOR NAME Martin D. Lawson				24b. ADDRESS 10 W. Padonia Rd. Timonium		25a. DATE REC'D. BY REGISTRAR MAR 19 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Mrs. Edith Macristy			March 28 1984			240 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		
Female	Caucasian	October 24 1901	82 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF U.S. COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Illinois	U.S.A.			Baltimore County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown	Baltimore County General Hospital			Home Maker			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Baltimore	Villa Nova			3907 Buckingham Road 21207	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
James Harry Wrigley			Elizabeth McVay Wrigley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No			041-24-9084		Mrs. Marjorie DeVees 3907 Buckingham Road Baltimore Maryland 21207		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

4275
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Sudden

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Metastatic C. Breast C.O.P.D.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>80</u> , to <u>3-28</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>3/28</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.						
22b. SIGNATURE <u>Lawrence Solomon MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-28-84</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LAWRENCE SOLOMON MD</u>				22e. ADDRESS <u>600 Rosetown Rd.</u>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	March 29, 84	Westview Crematory	Catonsville Baltimore Maryland
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>MAR 30 1984</u> <u>Jana Robinson-Jendell</u>

BP

2000 January 10
JAMES EARL RAY, JR.
1000 1/2 South Main Street, St. Louis, Mo.
St. Louis, Mo. 63101
Raymond J. ...
Raymond J. ...

RAY, JR.
JAMES EARL RAY, JR.
1000 1/2 South Main Street, St. Louis, Mo.
St. Louis, Mo. 63101
Raymond J. ...
Raymond J. ...

RAY, JR.
JAMES EARL RAY, JR.
1000 1/2 South Main Street, St. Louis, Mo.
St. Louis, Mo. 63101
Raymond J. ...
Raymond J. ...

RAY, JR.
JAMES EARL RAY, JR.
1000 1/2 South Main Street, St. Louis, Mo.
St. Louis, Mo. 63101
Raymond J. ...
Raymond J. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First MARGARET	Middle MAE	Lost MADDOX	2a. DATE OF DEATH Month 3 Day 7 Year 84			2b. HOUR 1:50 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 19, 1894		6. AGE (In years last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.					
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Meridian Nursing Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerical			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 100 Ashmere Rd. - 21117		
14. FATHER'S NAME First Samuel Middle Maddox Lost Conner			15. MOTHER'S MAIDEN NAME First Laura Middle Conner Lost Conner								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-42-6106		17. INFORMANT Address Martha Smith - same as 13 abcde						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) old age, Cardiorespiratory failure 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) old age, ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-22-1978 , to Feb, 1984 , that (I) (we) last saw the deceased alive on 10-1-84 , 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE Babu Y. Rao, M.D.			22c. ADDRESS 8811 Liberty Rd. - Randallstown, MD 21133			22d. DATE SIGNED 3/8/84					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/10/84			23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery			23d. LOCATION (City or Town) (County) (State) Marion - Somerset - MD		
24. FUNERAL DIRECTOR Bradshaw & Sons - 306 W. Main St. - Crisfield, MD 21817			25a. REC'D BY REGISTRAR MAR 14 1984			25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR		
6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR MONTHS DAYS			8. UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			11. KIND OF BUSINESS OR INDUSTRY		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE		
22c. DATE SIGNED			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
23d. LOCATION CITY OR TOWN COUNTY STATE			24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mrs. Lena Vera Maranto			2a. DATE OF DEATH MONTH DAY YEAR March 31 1984			2b. TIME 6:15 AM				
1. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 15 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Lochearn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3621 Campfield Road	
14. FATHER'S NAME FIRST MIDDLE LAST Biagio Lascola			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unknown			16. SOCIAL SECURITY NO. 220-44-3760				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-44-3760			17. INFORMANT Mr. Charles Maranto ADDRESS 8405 Echo Road Pasadena Maryland 21122				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial heart failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Sinus syndrome APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days 12 yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/31 19 84 to 3/31 19 84 , that (I) (we) last saw the deceased alive on 3/31 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE V. NARAYEN			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/31/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. NARAYEN			22e. ADDRESS BCGH							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 04-3-84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.						25a. DATE REC'D. BY REGISTRAR APR 3 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		
26. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133										

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR	
FIRST MIDDLE LAST Mary Ann Markey					MONTH DAY YEAR March 11, 1984			2 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR Nov. 15, 1897		86 YRS.		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Stoneleigh		Armcast Nursing Home				Homemaker			
13a. STATE					13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		
Md					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
William Dandy					Mary Elizabeth Leonard				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					220 44 6738		Lutherville, Maryland Alma Mc Cartin 1522 Pickett Road 21093		
18. CAUSE OF DEATH (Enter only one cause per line for each cause.)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10 March 1984 to 11 March 1984, that (I) () lost saw the deceased alive on 10 March 1984, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () did not view the body after death.									
22b. SIGNATURE Dr. Charles O'Donnell					22c. ADDRESS 7501 York Road			22d. DATE SIGNED 3/12/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial					3/14/84		St. Mary's Cemetery		Baltimore, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR				
Burgee Funeral Home 3631 Falls Road 21211					MAR 13 1984				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

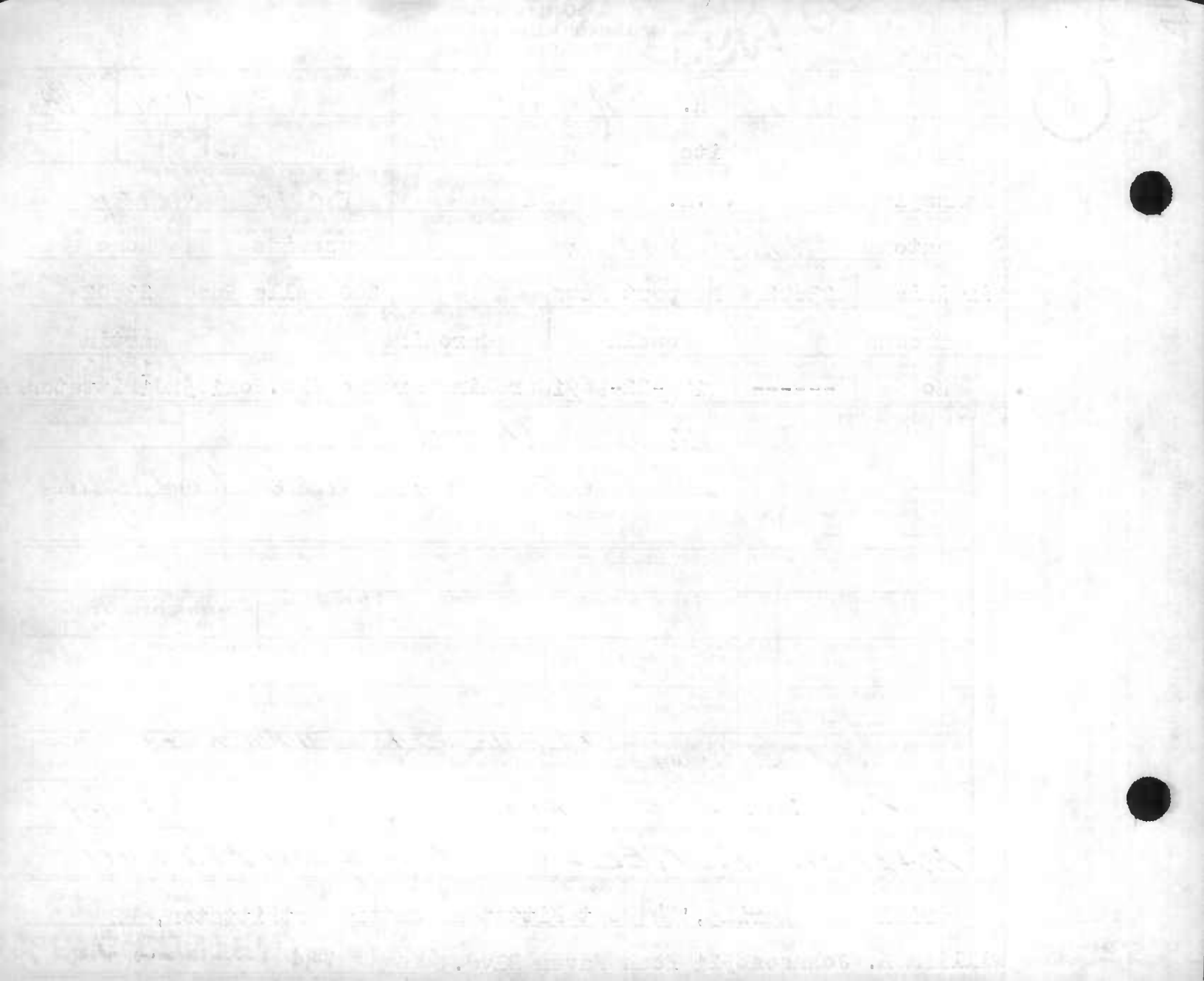
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna R. Martin			2a. DATE OF DEATH MONTH DAY YEAR 3 - 31 - 84		2b. HOUR 8:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 5 97	6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto County MD.		
10. CITY OR TOWN OF DEATH Ruxton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Ruxton	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia		13b. COUNTY 23602	13c. CITY OR TOWN Newport News	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 200 Wells Road 23602
FATHER'S NAME FIRST MIDDLE LAST Thomas Powell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Martin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 179-22-9691	17. INFORMANT ADDRESS 18643 Caroline Drummond P.O. Box 165 Rd 1 Pittston PA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4292 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 17 Feb 19 84 to 31 March 19 84 , that (I) (we) last saw the deceased alive on yesterday 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Walter T. Kees		DEGREE MD		22c. DATE SIGNED 3-31-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER T. KEES		22e. ADDRESS Monkton MD 21111			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 5, '84	23c. NAME OF CEMETERY OR CREMATORY West Pittston Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE West Pittston, PA	
24. FUNERAL DIRECTOR NAME William E. Johnson		ADDRESS 8521 Loch Raven Blvd.		25a. DATE REC'D. BY REGISTRAR APR 2 - 1984	25b. REGISTRAR'S SIGNATURE W. Davidson-Randell



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY MATTIA			2a. DATE OF DEATH MONTH DAY YEAR 3-28-84		2b. HOUR 2:30 P.M.						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 1 YRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Newark N.J.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. Gen. Hospt.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Mechanic		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 121 Glyndon Dr. 21136			
14. FATHER'S NAME FIRST MIDDLE LAST Antonio Mattia				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teresa Furtola							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Mr. Thomas G. Mattia Brewster N.Y.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 4310 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT PREYED TO THE IMMEDIATE CAUSE OR CONDITION GIVEN IN PART I: (a) S/P CRANIOTOMY W/ EVACUATION OF INTRACEREBRAL HEMATOMA											
19a. DATE OF OPERATION 3-8-84 3-21-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRACEREBRAL HEMATOMA EVACUATION TRACHEOSTOMY due to COMA				19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3-8 19 84 3-28 19 84							
22a. I certify that (I) (this hospital) attended the deceased from 3-8 19 84 to 3-28 19 84 , that (I) (we) lost saw the deceased alive on 3-28 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
22b. SIGNATURE Orlando B. Conaway MD.				DEGREE MD.				22c. DATE SIGNED 3-28-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS BCHH - RANDALLSTOWN Rd. 21133							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 31, 84		23c. NAME OF CEMETERY OR CREMATORY Providence Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md.				25a. DATE REC'D. BY REGISTRAR APR 3 1984		25b. REGISTRAR'S SIGNATURE Davidson					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06404

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN P. MCAVINUE			2a. DATE OF DEATH MONTH DAY YEAR 3-27-84		2b. HOUR 1:35 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 10 24		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inform. Officer		12b. KIND OF BUSINESS OR INDUSTRY State of Md.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY BALTO.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William McAvinue		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Mullen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 199-18-3328		17. INFORMANT ADDRESS Mrs. Agnes McAvinue - Same as #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS 13 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 3-24 19 84 , to 3-27 19 84 , that (we) last saw the deceased alive on 3-27 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did not) view the body after death.					
22b. SIGNATURE Jorge C. Secada-Lovio, M.D.		DEGREE MD.		22c. DATE SIGNED 3-27-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE C. SECADA-LOVIO, M.D.		22e. ADDRESS ST. JOSEPH HOSPITAL 7620 YORK RD. TOWSON, MD. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 3/27/84	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAR 28 1984	25b. REGISTRAR'S SIGNATURE ha Davidson

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 4 and 7 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHERINE C. MCCUBBIN				2a. DATE OF DEATH MONTH DAY YEAR MAR 5, 1984		2b. HOUR 3:20 P.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10/30/01		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 82 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 809 ARNCLIFFE RD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 809 ARNCLIFFE RD		13f. CITY OR TOWN ESSEX		13g. STATE MD		13h. ZIP CODE 21221	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BRENNAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. LYONS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 215 01 9273	
17. INFORMANT ADDRESS CLED HORD ABOVE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 METASTATIC CANCER OF THE LUNG OF UNKNOWN PRIMARY (b) UNKNOWN PRIMARY (c) UNKNOWN PRIMARY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 3, 1984 , to MARCH 5, 1984 , that (I) (we) lost the deceased alive on MARCH 5, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J.M. Juranay, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.M. JURANAY, M.D.		22e. ADDRESS CHURCH HOSPITAL, 100 N. BROADWAY		22f. CITY OR TOWN COUNTY STATE BALTO. MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/8/84		23c. NAME OF CEMETERY OR CRYPTORY MORELANDS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD	
24. FUNERAL DIRECTOR NAME J.G. CONNELLY		ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR MAR 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/interment permit. Then please remove carbon copies. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 06406	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
CARL C MCDADDE			03 - 12 - 84			M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
M		W		11 - 17 - 10		73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
N.C.		USA				BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (LINE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		ST. JOSEPH HOSPITAL		Chem. Engineer		Meat Packing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE	
MD		BALTIMORE				6201 LEITH WALK -39	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Carl Compton McDade				Lessie Haley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		WW 11		Mrs. Ella L. McDade 6201 Leith Walk			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic M.I.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>AS CVT</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 45 min</u> <u>15 days</u> <u>20 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital) attended the deceased from <u>2/20/84</u> 19 <u>84</u> to <u>3/12/84</u> 19 <u>84</u> , that I (we) last saw the deceased alive on <u>3/12/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23a. SIGNATURE OF PHYSICIAN				DEGREE		22c. DATE SIGNED	
<u>Thomas D. Messina M.D.</u>						<u>3/12/84</u>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
<u>Thomas D. Messina M.D.</u>				<u>7401 Osler Dr. Towson Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3/17/84		Oak Grove Cem.		Portsmouth, Va.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.				MAR 16 1984 <u>Julia Davidson-Randall</u>			

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "The", "of", "and" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

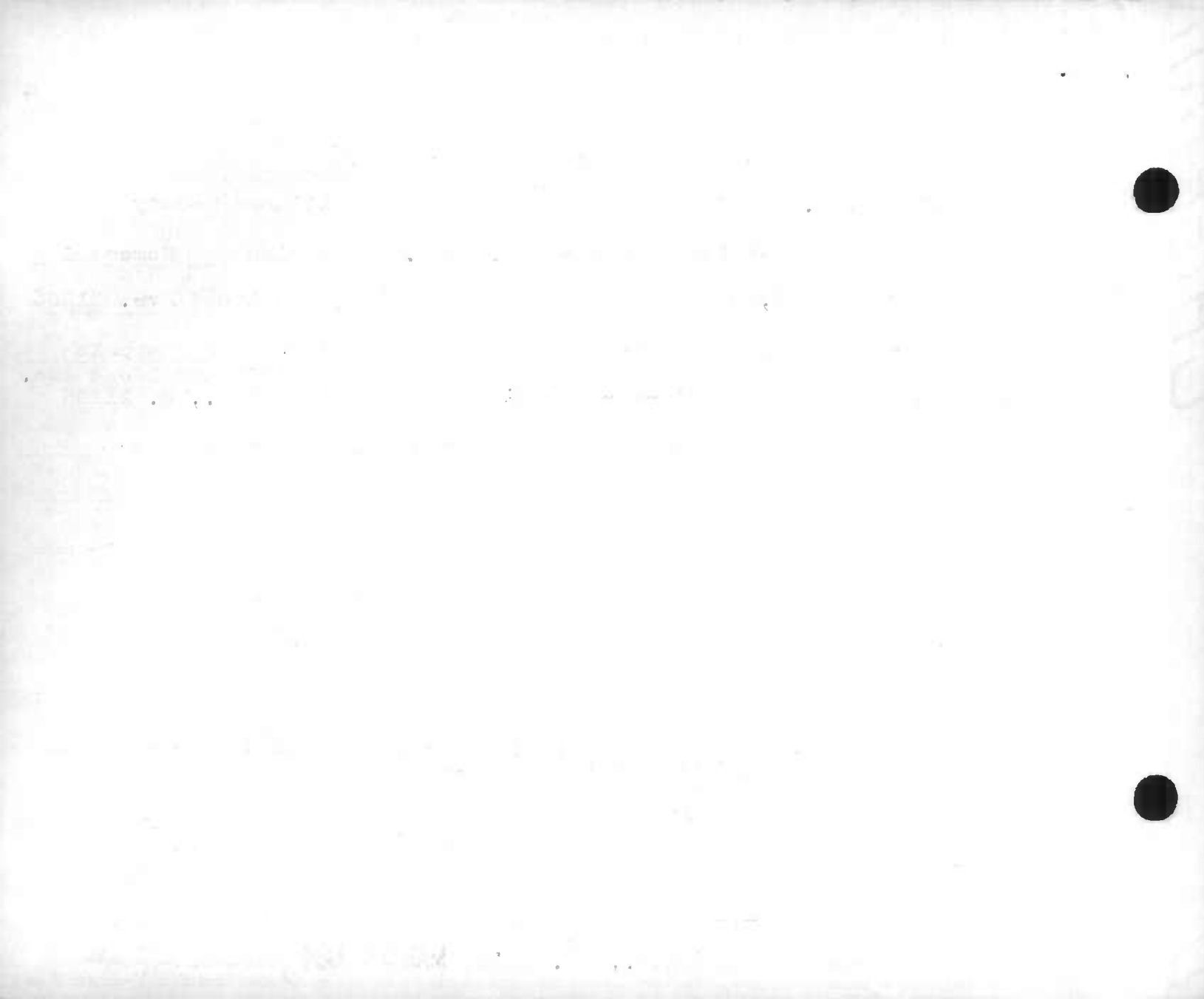
06407

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie C Mr Donald			2a. DATE OF DEATH MONTH DAY YEAR 03 04 84		2b. HOUR 0650 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 15 07	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Homemaking	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Groves		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Roppelt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-16-4024	17. INFORMANT ADDRESS 4917 Hazelwood Ave. Eileen Humphreys Balto., Md. 21206		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 6/16, 1982, to 3/4, 1984, that (I) (we) saw the deceased alive on 2/21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D.K. BEARD, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 11 E. Chestnut Hill La Reisterstown, Md 21136			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-7-84	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		25a. DATE REC'D. BY REGISTRAR MAR 08 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 6 4 0 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN LAWRENCE McNAMEE			2a. DATE OF DEATH MONTH DAY YEAR MARCH 26, 1984		2b. HOUR P 3:25 M		
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 24 1917		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairman		12b. KIND OF BUSINESS OR INDUSTRY Electric	
13a. STATE MARYLAND				13b. CITY OR TOWN P. GEORGES LANHAM		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13d. STREET ADDRESS / ZIP CODE 9857 GOOD LUCK ROAD #1 20706				14. FATHER'S NAME FIRST MIDDLE LAST James Eugene McNamee			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Alexander				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII			
16b. SOCIAL SECURITY NO. 227 01 4496				17. INFORMANT ADDRESS Elizabeth L. McNamee 9857 Good Luck Rd CLINICAL RECORDS, VAMC, FORT HOWARD, MD			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **BILATERAL PNEUMONIA**

4960
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **CHRONIC RESPIRATORY FAILURE ON MECHANICAL VENTILATION**

DUE TO, OR AS A CONSEQUENCE OF

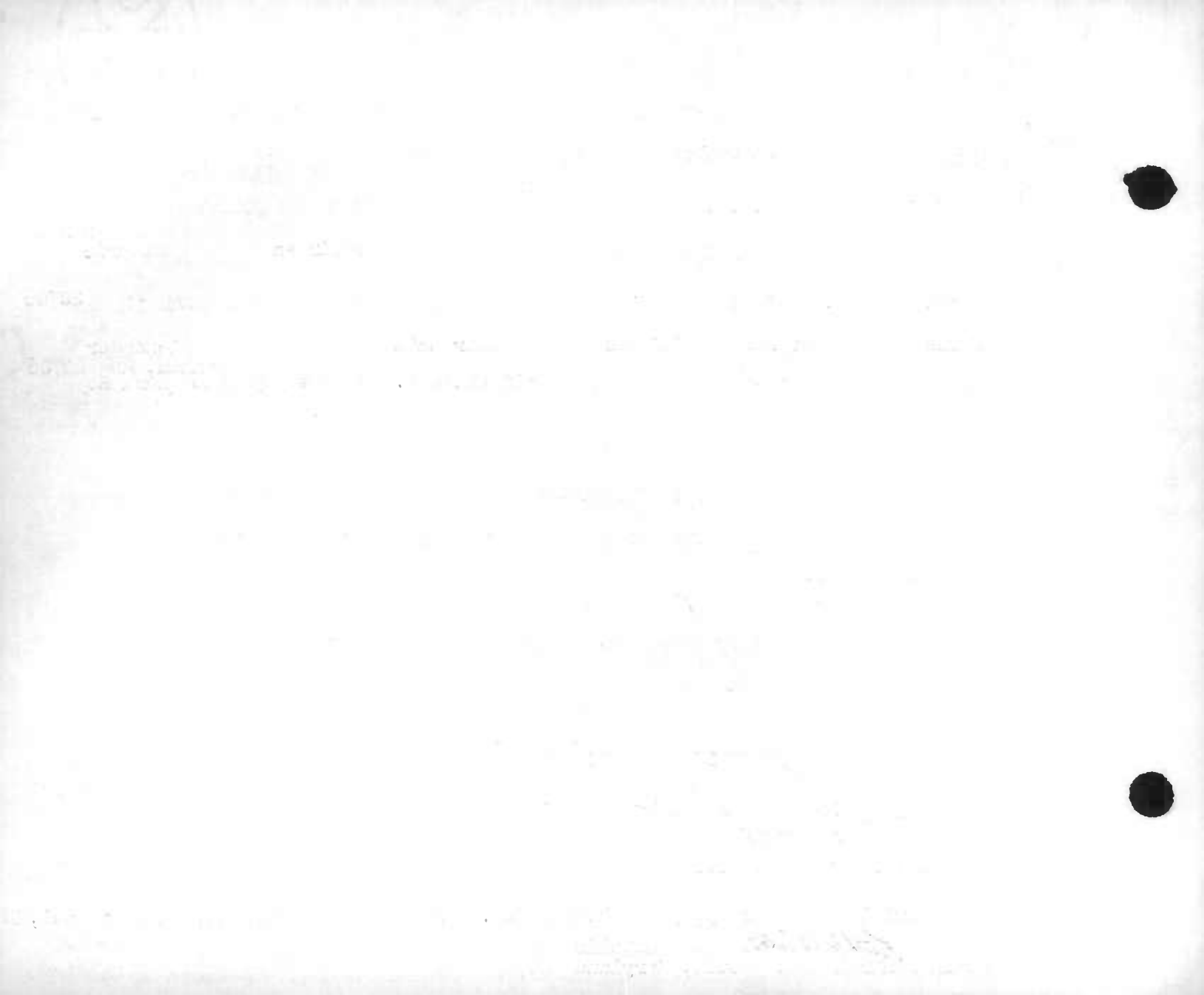
(c) **ADVANCED CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

COS PULMONALE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 21, 1983 to MARCH 26, 1984 , that (I) (we) last saw the deceased alive on MARCH 26, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>C.V.J. Vergheze</i> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.V.J. VERGHESE, M.D.				22e. ADDRESS VA MEDICAL CENTER, FORT HOWARD, MD 21052			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 29, 1984		23c. NAME OF CEMETERY OR CREMATORY Lakemont Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville, Anne Arundel, MD	
24. FUNERAL DIRECTOR NAME Beall Funeral Home				16000 Annapolis Road Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR APR 2 1984	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06409

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST TERESA MIDDLE Theresa		LAST MECHLINSKI		2a. DATE OF DEATH MONTH DAY YEAR March 26, 1984			2b. HOUR 7:58PM		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9/5/91		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 332 10A AVE.		21221	
14. FATHER'S NAME FIRST MIDDLE LAST UNK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216 093085		17. INFORMANT ADDRESS MARIE BRASKOWSKI ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 0384 IMMEDIATE CAUSE (a) Gram Negative Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10-21 , 19 83 , to 3-27 , 19 84 , that (I) (we) last saw the deceased alive on 10-21 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.											
22b. SIGNATURE John B. Littleton M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Littleton, M.D.						22e. ADDRESS 1012 Old North Point Rd.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/30/84		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD					
24. FUNERAL DIRECTOR NAME ADDRESS J.G. CONNELLY 300 MACE						25a. DATE REC'D. BY REGISTRAR MAR 29 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Maryland State Registrar, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Maryland State Registrar within 72 hours of death.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR	
FIRST MIDDLE LAST LOUISE M. METCALF					MONTH DAY YEAR March 12 1984			11 20 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR May 8, 1928		55 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD		USA				Baltimore County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Manor Care Ruxton				Homemaker		Own Home	
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		
MD					Balto.		117 Overbrook Rd. 21212		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Charles O'D. Mackall					Louise Bonner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					213 26 7132		William G. Boyce, Jr., Balto., MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) Cirrhosis of liver									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>Walter F. Kees</u> attended the deceased from <u>28 October 84</u> to <u>12 March 84</u> , that (I) <u>lost</u> saw the deceased alive on <u>12 March 1984</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If true, did I <u>not</u> view the body after death.)									
22b. SIGNATURE <u>Walter F. Kees</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12 March 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter F. Kees			22e. ADDRESS Monkton MD 21111						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/15/84		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Towson, MD		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212					25a. DATE REC'D. BY REGISTRAR MAR 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

6.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Belle MIDDENDORF		March 20, 1984		2:28pm	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	11-17-08	75	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore County		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Franklin Square Hospital		Housewife		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
Carroll	Rosenstein	Anna Kapplin		5510 Cedella Ave. 21206	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		219-03-5613	Winfield Middendorf, Sr. Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1: DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Hepatic Encephalopathy					
IMMEDIATE CAUSE (a)					
5714 DUE TO, OR AS A RESULT OF, Macromodular Cirrhosis					
(b)					
DUE TO, OR AS A RESULT OF, Chronic Active Hepatitis					
(c)					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
Upper Gastrointestinal Bleeding, Ascites					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 24, 1984, to March 20, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 20, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Lawrence R. Bell		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		3/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Lawrence Bell, M.D.		9000 Franklin Square Drive			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3-23-84	Gardens of Faith	Baltimore, Balto. Md.	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Leonard J. Ruck, Inc., 5305 Harford Rd.			MAR 22 1984		Julia Davidson-Randall

RECEIVED

11-11-11

White

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U.S.A.

U.S.A.

11-11-11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AMANDA MILLER			2a. DATE OF DEATH MONTH DAY YEAR 3 27 84			2b. HOUR 5:30 AM					
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 6 1886		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3202 Riverdrive Road 21219		
14. FATHER'S NAME FIRST MIDDLE LAST William Wyatt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-20-1513		17. INFORMANT Thelma Douglas		ADDRESS 1925 Stanhope Rd. Balto., MD. 21222				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 42775 DUE TO, OR AS A CONSEQUENCE OF (b) Old age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Dementia, C.H.F., Atrial fibrillation											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Hafeez A Syed			DEGREE			22c. DATE SIGNED 3/27/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFEEL A SYED			22e. ADDRESS BALTIMORE COUNTY GEN HOSP.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/30/1984		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222						25a. DATE REC'D. BY REGISTRAR MAR 29 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

AMERICAN WHITE 3 CLASS 98
MILK 3 27 54 3 44

Can handle 1 quart
last year

1000 lbs. of milk
per year

1000 lbs. of milk
per year

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified as soon as possible.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06413					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST Jessie MILLER				March 7, 1984				1:40am	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 18 1916		6. AGE (IN YEARS LAST BIRTHDAY) YRS 67		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. & Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wallace Malanowski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Czakowski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 220-36-1463		17. INFORMANT ADDRESS Frank Malanowski 1561 Lockwood Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 6, 1984, to March 7, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 7, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE De la Hunt				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) De la Hunt M.D.				22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-10-84		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR John M. Weber & Sons Inc. 401 S. Chester St.				25a. DATE REC'D. BY REGISTRAR MAR 9 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06414

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William O. MILLER			2a. DATE OF DEATH MONTH DAY YEAR March 7, 1984			2b. HOUR 12:45pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 28 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.-Annuant U.S. Govern-ment	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN 216 Leslie Ave. 21236	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madeline			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 212-44-1330		17. INFORMANT ADDRESS 4701 Mawani Rd. Mrs. Merle Smith Balto., Md. 21206			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
Cardiac Arrest

IMMEDIATE CAUSE (a)

4100
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Congestive Heart Failure

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from February 12, 19 84, to March 7, 19 84, that (x) (we) last saw the deceased alive on March 7, 19 84, and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (X) (not) view the body after death.							
22b. SIGNATURE mshafi		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAFI				22e. ADDRESS 9000 Franklin Square Drive			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 3-9-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Lassan Funeral Home 7401 B-1 Rd. (21236) MAR 14 1984							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06715

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elihu MODLIN, Sr.			2a. DATE OF DEATH MONTH DAY YEAR March 25, 1984		2b. HOUR 2:47 PM		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 26 98		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS 85 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Mark R. Modlin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Overton		13e. STREET ADDRESS / ZIP CODE 6001 Radecke Avenue 21206			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 213-09-1908		17. INFORMANT ADDRESS Bessie N. Modlin 6001 Radecke Avenue			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost

(b) **Probable Myocardial Infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that ☒ (this hospital) attended the deceased from **March 25**, 19 **84**, to **March 25**, 19 **84**, that ☒ (we) lost
saw the deceased alive on **March 25**, 19 **84**, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated
above, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE Isadore Feldman	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/25/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Isadore Feldman	22e. ADDRESS Franklin Square Hosp.		

23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 3/30/84	23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, MD.
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24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E. North Avenue	25a. DATE RECD. BY REGISTRAR MAR 28 1984	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by a physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MAR 10 1964

RECEIVED

MAR 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) RAYMOND R. MOFFETT					2a. DATE OF DEATH MONTH DAY YEAR MARCH 19 '84			2b. HOUR 3:10 P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 22 08		6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.					
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EAST POINT NSG. HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY SALES		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3205 OVERLAND AVE. 21214			
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT C. MOFFETT					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA REED.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES NW II				16b. SOCIAL SECURITY NO. 213-12-8925		17. INFORMANT ADDRESS MARYBELLE MOFFETT (SAME AS 13.)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Cardiovascular Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 2 years long term	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3-19-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (all) did not view the body after death.											
22b. SIGNATURE [Signature]						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-19-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Name]						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MARCH 24, 1984		23c. NAME OF CEMETERY OR CREMATORY CHESTER CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE CHESTERTOWN KENT MD.			
24. FUNERAL DIRECTOR NAME Barrenco Funeral Home						ADDRESS 21146 Severna Park		25a. DATE REC'D. BY REGISTRAR MAR 27 1984			
						25b. REGISTRAR'S SIGNATURE [Signature]					

BP.



BAKIN

EASTMONT AND WESTMONT

BAKIN COUNTY

March 21 1904

Raymond J. Moffatt

March 21 1904

March 21 1904

Business Administration Center, Georgetown, Kent, Ohio

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN EDWARD MONELL					2a. DATE OF DEATH MONTH DAY YEAR 3 12 84				2b. HOUR 8:00 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 6 21		6. AGE (IN YEARS LAST BIRTHDAY) 63		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		7b. IF UNDER 24 HRS. HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH Wynnewood		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1113 Plover Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Delegate of NATO		12b. KIND OF BUSINESS OR INDUSTRY Dept. of Navy			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Wynnewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Robert Edward Monell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucile McGraw						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII & Korea 225-16-9030		17. INFORMANT ADDRESS Margie W. Monell 1113 Plover Drive 21227				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) acute infarcting myocardium DUE TO, OR AS A CONSEQUENCE OF (b) NASCAR DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/24 19 84 , to 3/15 19 84 , that (I) (we) lost saw the deceased alive on 2/24 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eugenio Benitez						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/84	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Eugenio Benitez						22e. ADDRESS St. Agnes Medical Center					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/16/84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						25a. DATE REC'D. BY REGISTRAR MAR 16 1984		25b. REGISTRAR'S SIGNATURE S. Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR					STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) MAMIE BESSIE MORGAN					2a. DATE OF DEATH MONTH 3 DAY 18 YEAR 84					2b. HOUR 5:45 AM				
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH JUNE 8, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS 3 DAYS 12		7b. IF UNDER 24 HRS. HOURS MIN. 				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.								
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Catonsville								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21211						
14. FATHER'S NAME FIRST Roger MIDDLE D LAST Breckenridge		15. MOTHER'S MAIDEN NAME FIRST BESSIE MIDDLE ELIZABETH LAST White												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-22-9353		17. INFORMANT ADDRESS Mr. Carlos D. Breckenridge				107 Water Street Frederick, Md. 21701						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) cardiorespi. arrest DUE TO, OR AS A CONSEQUENCE OF (b) severe COPD DUE TO, OR AS A CONSEQUENCE OF (c) 														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3/18/84 , 19 84 , to 3/18/84 , 19 84 , that (I) (we) last saw the deceased alive on 3/18/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Nayan Vaywala M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NAYAN VAYWALA								22e. ADDRESS 301 St Agnes Med Ctr Balt MD 21228						
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 3-21-1984				23c. NAME OF CEMETERY OR CREMATORY Fred.Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.		
24. FUNERAL DIRECTOR Robert E. Dailey & Son, PA				1201 N. Market St. Frederick, Md. 21701				25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP

WILLIAM E. MURPHY

1924

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BLANNIE BRYANT MORRIS			2a. DATE OF DEATH MONTH 3 DAY 19 YEAR 84 TIME 5:45 P.M.		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 1 DAY 1 YEAR 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Woodlawn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST John MIDDLE R. LAST Elliott			15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE Belle LAST Belle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-22-1718		17. INFORMANT Vivian Dunn ADDRESS 1703 Fairbrook Court 21207

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **4292**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (I) (this hospital) attended the deceased from **3-12-84**, to **3-19-84**, that (I) (we) lost
saw the deceased alive on **3-19-84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Soonchul Hong	DEGREE	22c. DATE SIGNED 3-19-84
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOONCHUL HONG	22e. ADDRESS Baltimore County General Hosp.
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/22/84	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk	23d. LOCATION CITY OR TOWN COUNTY Elkridge Howard Maryland
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24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.	ADDRESS 4107 Wilkens Ave.	25. DATE REC'D. BY REGISTRAR MAR 21 1984
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST LORETTA E. MUELLER				March 11, 1984			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 31, 1908		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS 75 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1226 Stella Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS / ZIP CODE 1226 Stella Drive 21207	
14. FATHER'S NAME FIRST MIDDLE LAST George Albert Shanahan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Sommers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-07-6675		17. INFORMANT ADDRESS Yvonne Cerniglia Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 5188 IMMEDIATE CAUSE (a) Cerebral Respiration failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory pulmonary infection CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instantaneous unk. time
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Arterio-sclerotic cardiovascular disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET			
22a. I certify that (I) (the hospital) attended the deceased from 6/1/58 19 58 , to 3/11 19 84 , that (I) (we) last saw the deceased alive on 2/10 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Clifford Ratliff M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clifford Ratliff M.D.				22e. ADDRESS 5772 Westview Mall. Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 3/15/84		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Md.	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 13 1984 John Davidson Wendell			
1630 Edmondson Avenue, Catonsville, Md. 21228							

1009 Edmondson Avenue, Los Angeles, 14, California

U. N. 711348 BX097113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Michael J. Mueller				2a. DATE OF DEATH MONTH DAY YEAR 3 28 '84		2b. HOUR 7A M.	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 7 14 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.			
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Balto 13c. CITY OR TOWN Towson				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 305 E. Joppa Road 21204	
14. FATHER'S NAME FIRST MIDDLE LAST George A. Mueller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Herman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 415-03-0434		17. INFORMANT ADDRESS Stella Maris Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CORD DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 4292							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 83 , to 3-27 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kendall R Faulkner MD		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-28-1984			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kendall R. Faulkner M.D.		22e. ADDRESS Stella Maris / Dulaney Valley Rd.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-30-84		23c. NAME OF CEMETERY OR CREMATORY St. John's Long Green		23d. LOCATION CITY OR TOWN COUNTY STATE Long Green Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR MAR 29 1984		25b. REGISTRAR'S SIGNATURE [Signature]	



Each Townon Mineral Land, Inc. 1050 York Rd. 3-30-84 25. John's Long Green Land Green Maryland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06422

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Glen E. MULLINS			2a. DATE OF DEATH MONTH DAY YEAR March 15, 1984			2b. HOUR 7:00P M			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12 25 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RAILROAD		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 431 53RD ST 21224	
14. FATHER'S NAME FIRST MIDDLE LAST S. PURGEON MULLINS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIE IRWIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS LILLIAN MULLINS 431 53RD ST 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Liver Adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Colon Adenocarcinoma</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>February 20</u> , 19 <u>84</u> , to <u>March 15</u> , 19 <u>84</u> , that <u>xx</u> last saw the deceased alive on <u>March 15</u> , 19 <u>84</u> , and that in <u>xx</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>xx</u> (we) (did) (not) touch the body after death.									
22b. SIGNATURE <u>Leslie Muraw</u>			DEGREE			22c. DATE SIGNED 3/15/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LESLIE MURAW			22e. ADDRESS 9000 Franklin Square Dr., 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/19/84			23c. NAME OF CEMETERY OR CREMATORY OAK LAWN			
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			24. FUNERAL DIRECTOR NAME CONNELLY F.H. 300 MACE AVE.			25a. DATE REC'D. BY REGISTRAR MAR 21 1984			
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randell</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



1245.125 5210.03

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06423

1 - FOR
STATE
REGISTRAR

REG. NO.

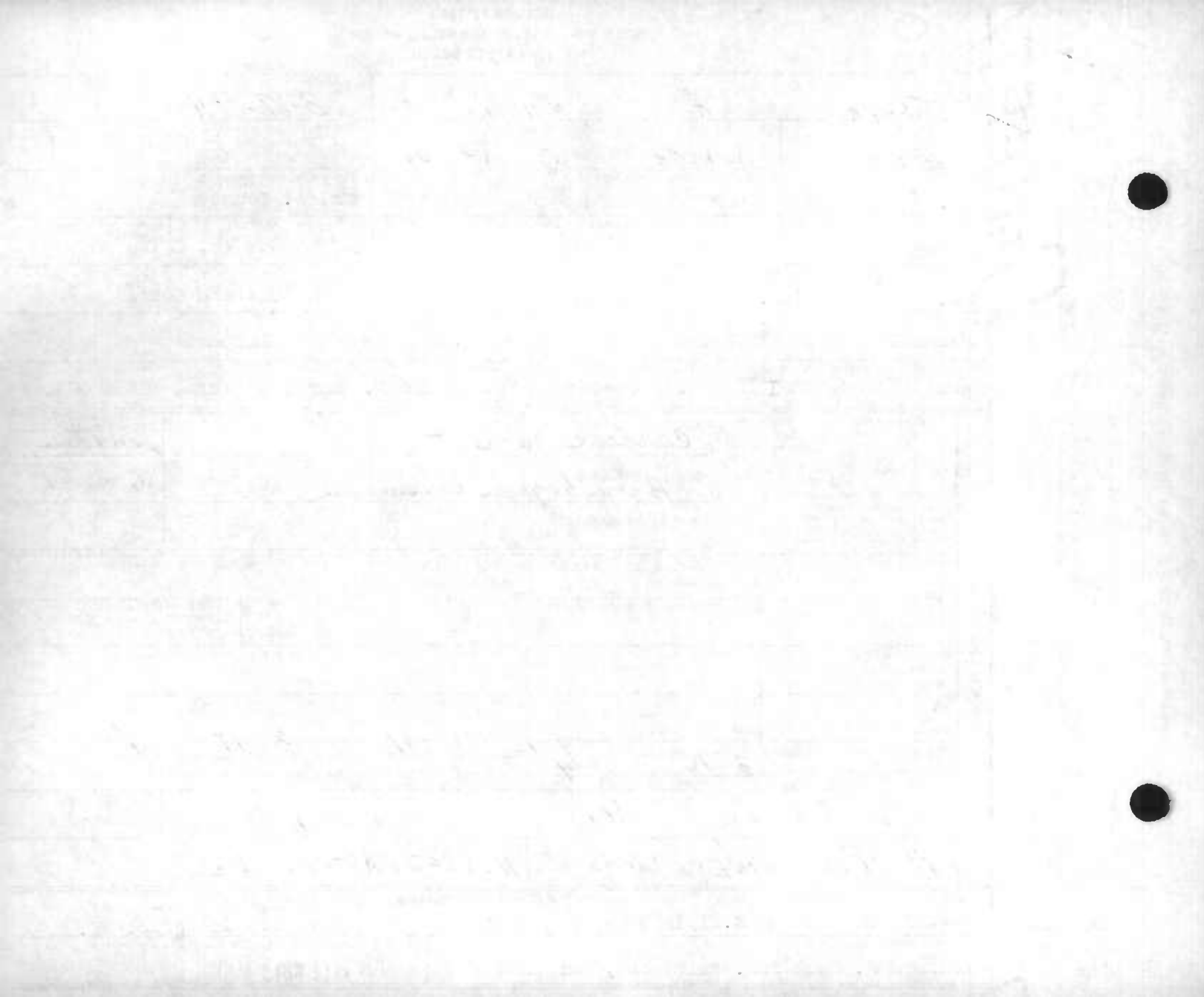
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Joseph			A.	Murphy Sr.	3-17-84					M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		3 19 00		83 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA				Balto. County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Essex		Riverview Nursing Home				Balto. G. & E. Co.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Balto.		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5 C. Westbend Court 81207			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Michael		Sarah		yes		212-05-4440		Mr. Thomas P. Murphy 8 Sturat Mills Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Bronchogenic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 months</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9-16</u> , 19 <u>81</u> , to <u>3-17</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3-16</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>M. Rainess</u>		DEGREE <u>MD.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MORRIS RAINESS, MD.</u>		22e. ADDRESS <u>1165 OLD EASTERN AVE.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Mar. 21, 1984		Dulaney Valley		Cockeysville Balto. Md.					
24. FUNERAL DIRECTOR NAME <u>Leonard J. Ruck Inc. Baltimore, Maryland</u>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson Randall</u>					
				MAR 20 1984							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 6 4 2 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mrs. Helen Murray			2a. DATE OF DEATH MONTH DAY YEAR March 29 1984			2b. HOUR 11:18 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 18 1908		6. AGE (IN YEARS - 1ST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HomeMaker		12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 705 Cloudyfold Drive		21208	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Murphy						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Jane Dunn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-38-7369		17. INFIRMITY Mrs. Helen L. Stalnaker		ADDRESS 705 Cloudyfold Drive		Pikesville		Maryland	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac asystole 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Resp. failure DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

27b. SIGNATURE HAFEE Z SYED M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		27c. DATE SIGNED 3/29/84	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFEE Z SYED M.D.				27e. ADDRESS BALTIMORE COUNTY GEN HOSP			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-31-84		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore Maryland	
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24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.		25a. DATE REC'D. BY REGISTRAR APR 3 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randell	
ADDRESS 8728 Liberty Road Randallstown, Maryland 21133					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is to be notified at once.

BP _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) BESSIE E. MUSGROVE					2a. DATE OF DEATH MONTH 3 DAY 13 YEAR 84				
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH 01 DAY 14 YEAR 88		6. AGE (IN YEARS LAST BIRTHDAY) 96		7b. HOUR 10:04 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co.		MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY MD		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21230 1252 Washington Blvd. Balto. Md.	
14. FATHER'S NAME FIRST George MIDDLE ----- LAST Wroten		15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE ----- LAST Kimmey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-74-6048		17. INFORMANT ADDRESS 21122 Ma. Calvin Musgrove, 1664 Glen Dr. Pasadena, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Caecum with small bowel obstruction 1534 DUE TO, OR AS A CONSEQUENCE OF (b) Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Obstruction									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Senile Dementia; ASD;									
19a. DATE OF OPERATION 3/13/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ASD		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE		21i. LOCATION STREET CITY OR TOWN COUNTY STATE		21j. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that we (this hospital) attended the deceased from 3/29/81 to 3/13/84 , that we last saw the deceased alive on 3/13/84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, we (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/23/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. M. TUN		22e. ADDRESS Manor care Rossville, md 21237		22f. ADDRESS Manor care Rossville, md 21237		22g. ADDRESS Manor care Rossville, md 21237		22h. ADDRESS Manor care Rossville, md 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 15, 1984		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cent.		23d. LOCATION CITY OR TOWN Baltimore, Maryland COUNTY Md STATE MD			
24. FUNERAL DIRECTOR McCutty Funeral Home, Mt. & Tickle Rd. Pasadena, Md. 21122		25a. DATE REC'D. BY REGISTRAR MAR 15 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		25c. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR STATE REGISTRAR		Items #5, 6 & 7a Film #G590		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		06426	
4/5/84 jp				CERTIFICATE OF DEATH		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Earl Alton MYERS Sr.				March 15, 1984				10:08 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		Caucasian		Aug. 12, 1901		82 74 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Essex		Franklin Square Hospital				Shipbuilder		Steel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Baltimore		Essex		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
Miles				Lilly		17 Ridgemoor Road 21221			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				172-01-5621		Marian Myers same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4100 Massive Coronary Thrombosis									
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.H.D.								10 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-19-81, 19____, to 1-3-1984, that (I) (we) last saw the deceased alive on 1-3-84, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED				22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
[Signature]				3-15-84				M. Gladden Kurtz	
22e. ADDRESS				23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					
				Burial					
				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
				3/17/1984		Bel Air Mem. Gar.		Bel Air Harford Md.	
24. FUNERAL DIRECTOR				25. DATE REC'D BY REGISTRAR					
M. Gladden Kurtz				MAR 22 1984					
Jarrettsville, Md.				25b. REGISTRAR'S SIGNATURE					
				Julia Davidson-Randall					

MEDICAL CERTIFICATION

BP _____

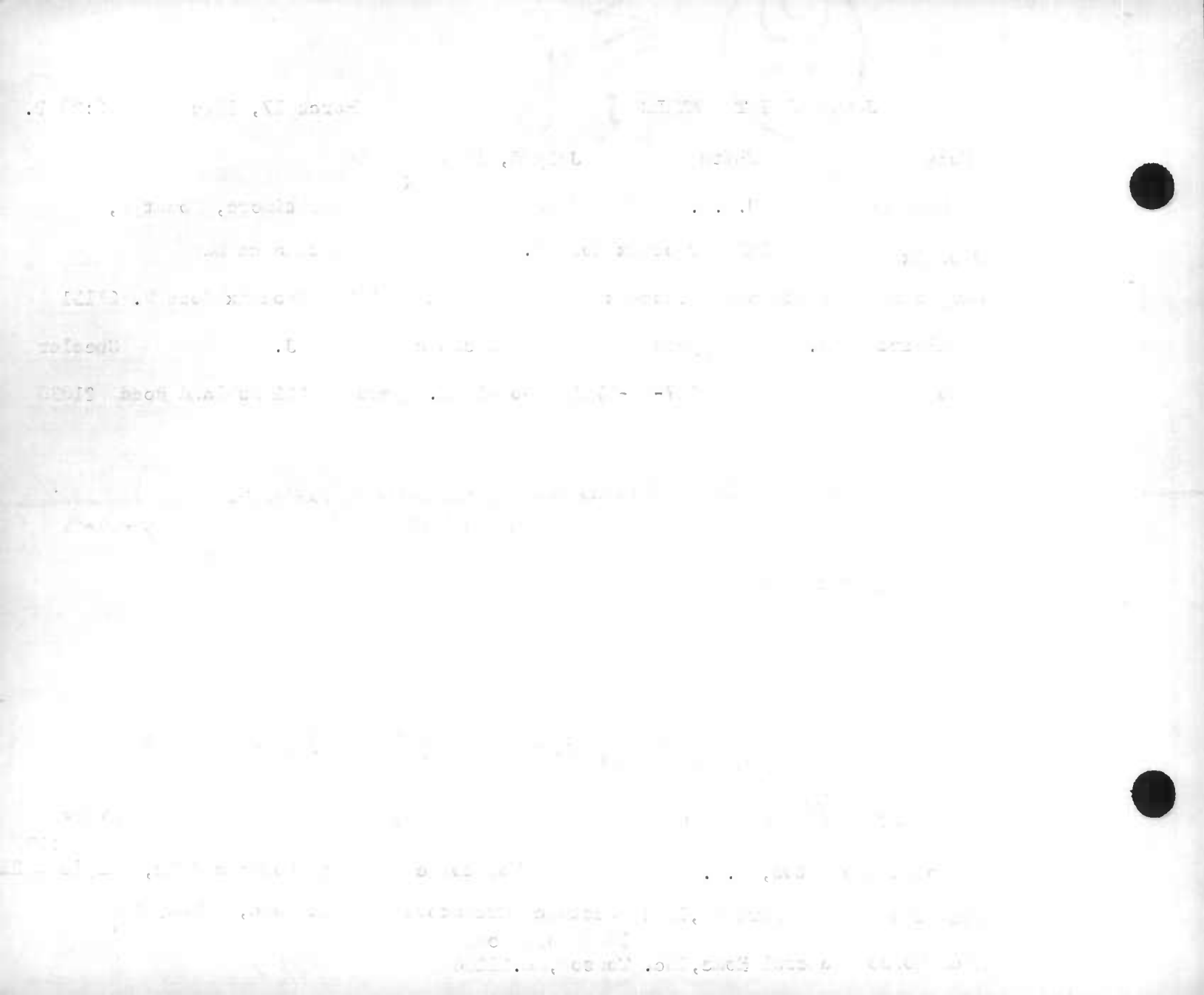
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2b. HOUR	
JOHN ALBERT MYERS		March 17, 1984		2:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	44 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore, County, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Phoenix	14308 Phoenix Road W.		Maintenance Man		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland	Baltimore	Phoenix	13e. STREET ADDRESS / ZIP CODE		
			14308 Phoenix Road W. 21131		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Albert A. Myers		Susanna J. Sheeler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-36-3742		Donald I. Myers 222 Ashland Road 21030	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4110 DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASEVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>OBESITY</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>75</u> to <u>March</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Jan. 21</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>B. Matos</u>		DEGREE		22c. DATE SIGNED <u>3/19/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Bienvenido Matos, M.D.		Yorcktowne Village Cockeysville, Maryland 2130			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		March 19, 1984		Westview Crematory	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		MAR 19 1984		<u>J. W. Davidson</u>	
Ruck Towson Funeral Home, Inc.		Towson, Md. 21204			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Joseph NAGLE			2a. DATE OF DEATH MONTH DAY YEAR March 7, 1984			2b. HOUR 10:30am			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 19, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County			
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Franklin Sq. Hospital				12a. USUAL OCCUPATION (TYPE OR VARIOUS MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Flowing Ctr.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN Md. Baltimore Middle River			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 75 Henderson Rd. 21220				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Nagle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Guilda						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 45-46 212 22 6424		17. INFORMANT ADDRESS Pauline Nagle, Wife Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma With Multiple Metastases DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN- COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 13, 1984 to March 7, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 7, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.									
22b. SIGNATURE A. Gittman M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Gittman, M.D.						22e. ADDRESS 9000 Franklin Square Drive			
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 3/9/84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION Baltimore, Md. COUNTY STATE		
24. FUNERAL DIRECTOR Brudzinski Funeral Home						25a. DATE REC'D. BY REGISTRAR MAR 9 1984		25b. REGISTRAR'S SIGNATURE W. H. H. H.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DOROTHY JENKINS NEELD			2a. DATE OF DEATH MONTH DAY YEAR 3-11-84			2b. HOUR 5:08 AM			
SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 10, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8007 York Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph H. Jenkins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Duvall			13e. STREET ADDRESS / ZIP CODE 8007 York Road 21204			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-32-3283		17. INFORMANT ADDRESS Mrs. Robert Mann 917 Rolandvue Road 21204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4300 DUE TO, OR AS A CONSEQUENCE OF (b) SUBARACHNOID HEMORRHAGE, C.A.D. DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL A.S. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 6 WKS Yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CARCINOMA OF BREAST									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1/13, 1975 , to 3/11, 1984 , that (I) (we) last saw the deceased alive on 3/5, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Donald L. Somerville, MD.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald L. Somerville					22e. ADDRESS 500 Virginia Ave. 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-14-84		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Towson Baltimore		
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212						25a. DATE REC'D. BY REGISTRAR MAR 13 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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2/13/12

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The funeral director must be notified of the death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.						
1. FOR STATE REGISTRAR																
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR		
Alverta E. Nemsick					3			31		84				M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		10 1 1903		80 YRS.			MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										
Virginia		U.S.A.				Baltimore County MD.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Baltimore City Hospital								Housewife			Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
13a. STATE					Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1924 Walnut Ave. 21222					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME											
Bernard Lanham					Ida V. Wright											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No					213-34-1656		Jack Nemsick, Jr. Balto., MD. 21237									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) <u>Acute myocardial infarct.</u>																
2506 DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.D. & history of Previous M.I.</u>												year				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus, Peripheral vasc. disease.</u>												year				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
				HOUR A.M. MONTH DAY YEAR												
				P.M. 19												
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION								
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from Nov. 9, 1964, to 3/31/84, 1984, that (I) (we) saw the deceased alive on Feb 21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED				
ATAOLLAH GOLPIRA, M.D.				M.D.								4/2/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS												
				3029 Dundalk Ave Balto, Md. 21222												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION						
Burial				4/3/84		Gardens of Faith				Baltimore Maryland						
24. FUNERAL DIRECTOR Duda-Ruck, Inc. ADDRESS																
7922 Wise Ave. Dundalk, MD. 21222																
25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE						
APR 5 1984										John Davidson Dundell						

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TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[Several lines of faint, illegible text follow, likely a memorandum format.]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06431

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Florence			FIRST MIDDLE LAST NEWBURGER			2a. DATE OF DEATH MONTH DAY YEAR March 5, 1984				2b. HOUR 2:55pm	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 22, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5621 BELLE VISTA AVE. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB COHEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA WEINER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-40-2408		17. INFORMANT KENNETH NEWBURGER ADDRESS APT. T-2 4 COACHMAN CT. RANDALLSTOWN, MD 21133					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Bilateral bronchopneumonia with multiple abscesses**

4850
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 9, 1984 to March 5, 1984 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 5, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE Jameela Y. Arshad, M.D.		DEGREE		22c. DATE SIGNED 3/5/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jameela Arshad, M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3/7/84		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR MAR 9 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP



Handwritten signature or initials.

Handwritten date: 11/2/4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06432

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Frederick NICELY			2a. DATE OF DEATH March 12, 1984			2b. HOUR 1:00pm _M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 18 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Franklin Square Hospital				12a. USUAL OCCUPATION Foreman Sparrows Point			12b. KIND OF BUSINESS OR INDUSTRY Shipyard		
10. CITY OR TOWN OF DEATH Baltimore		11a. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Franklin Square Hospital		11b. CITY OR TOWN Westminster		11c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11d. STREET ADDRESS / ZIP CODE 312 Royer Rd. 21157			
14. FATHER'S NAME Roy				15. MOTHER'S MAIDEN NAME Ann Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No				16b. SOCIAL SECURITY NO. 227-03-4449				17. INFORMANT Nellie A. Nicely same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Recurrent Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Probable Metastatic Carcinoma, Primary Undetermined DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from February 4, 1984, to March 12, 1984, that (we) last saw the deceased alive on March 12, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE Albert K. Lee M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3-12-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert Lee, M.D.						22e. ADDRESS 9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 3-15-1984			23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial			23d. LOCATION Finksburg Carroll Md.		
24. FUNERAL DIRECTOR Fletcher F. H.			25a. DATE REC'D. BY REGISTRAR MAR 16 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Lincoln NICHOLS					2a. DATE OF DEATH MONTH DAY YEAR March 29, 1984				2b. HOUR 1:00a M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-9-1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1046 Old North Pt. Rd. (37)			
14. FATHER'S NAME FIRST MIDDLE LAST Allen Nichols					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 168-01-6507		17. INFORMANT ADDRESS Bonnie Rodgers P.O. Box 9745 Arnold Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Severe Chronic Obstructive Pulmonary Disease (c) Adenocarcinoma Lung										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from March 8, 1984 , to March 29, 1984 , that (we) lost saw the deceased alive on March 29, 1984 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.											
22b. SIGNATURE C. Joseph, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/29/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 9000 Franklin Sq. Dr., 21237								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4-2-84		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Balto, B.C. Md.			
24. FUNERAL DIRECTOR NAME Charles A. Rice FSPA 1300 Eutaw Pl					25a. DATE REC'D. BY REGISTRAR APR 9 1984						
					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06434

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ROSE		3-17-84		915 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	WHITE	8-19-92	91 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.	Baltimore County	MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
	Perring Parkway Nursing Home		Housewife		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7100 Martell Avenue 21222	
Maryland	Baltimore	Dundalk			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Michael Lawicki		Marcyanna Novak			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
No		218-05-6174	7663 Old Battle Grove Road Balto., MD. 21222		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis -					
4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD -					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c) Old Age -					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-17-84 to 3-17-84, that (I) (we) lost saw the deceased alive on 3-17-84, and that in (my) (our) opinion death occurred on the date one hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Anthony F. Carozza		MD		3-19-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Anthony F. Carozza		1801 Wentworth Rd Balto MD 21234			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		3/21/1984	Sacred Heart Of Jesus Dundalk		CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Duda-Ruck, Inc.		MAR 22 1984		Julia Davidson Dundalk	
7922 Wise Avenue Dundalk, MD. 21222					



1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50
51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70
71	72	73	74	75	76	77	78	79	80
81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100

Handwritten notes and a small diagram, possibly a sketch of a building or structure.

Handwritten notes and a small diagram, possibly a sketch of a building or structure.



Handwritten notes and a small diagram, possibly a sketch of a building or structure.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

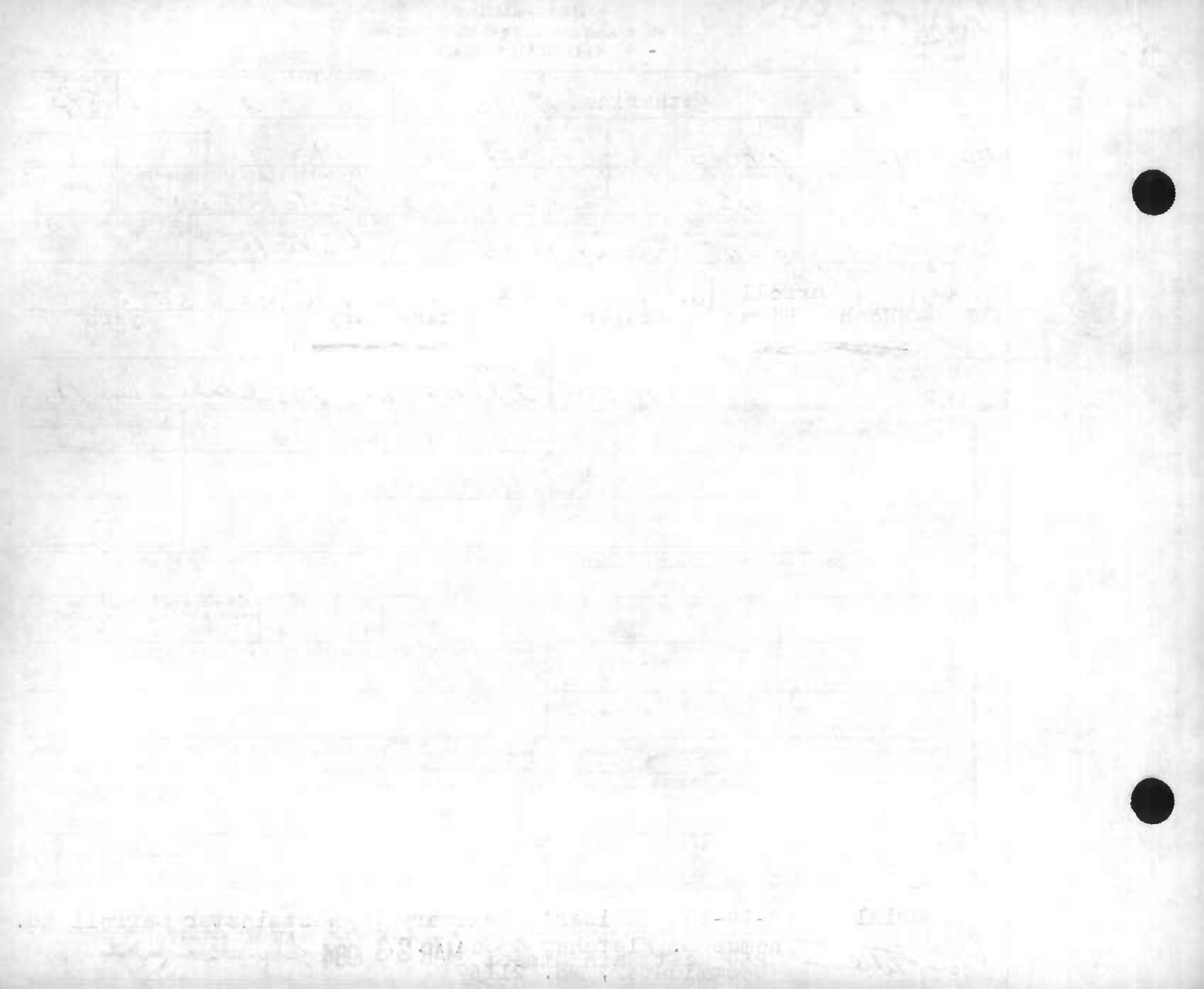
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) BERTHA Catherine NULL				2a DATE OF DEATH MONTH DAY YEAR 3 20 84				2b HOUR 8:30 M			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 4 22 88		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? USA	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH REGISTERSTOWN MD.		10 CITY OR TOWN OF DEATH REGISTERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BENT NURSING HOME		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD		13b COUNTY Carroll		13c CITY OR TOWN Westminster		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 166 W. MAIN ST. 21157			
14 FATHER'S NAME FIRST MIDDLE LAST Noah Hiram Kester		15 MOTHER'S NAME FIRST MIDDLE LAST UNKNOWN		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 216-14-5284		17 INFORMANT ADDRESS H. Jones Lpa 263 Hammershire Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Heart Failure Arteriosclerotic CV Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week Years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 11-9 1983, to 3-20 1984, that (I) (we) last saw the deceased alive on 3-20 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE O. E. McWilliams M.D.								22c DATE SIGNED 3-20-84			
22d PHYSICIAN'S NAME (TYPE OR PRINT) O. E. McWilliams								22e ADDRESS 11904 Registerstown Rd Registerstown MD 21136			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 3-24-84		23c NAME OF CEMETERY OR CREMATORY Krider's Cemetery				23d LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.	
24 FUNERAL DIRECTOR Thomas D. Fletcher & Son				25 ADDRESS 254 East Main Street Westminster, Md. 21157				26 DATE OF REGISTRATION MAR 23 1984			
27 REGISTRAR'S SIGNATURE John Davidson											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST EVA M OLSEN		MONTH DAY YEAR HOUR 3 - 2 - 84 1:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
F	W	MONTH DAY YEAR 8 - 27 - 97	YRS. MONTHS DAYS HOURS MIN. 87
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	U. S. A.		Baltimore County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Catonsville	St. Joseph's Nursing Home		Receptionist
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
MD.	Baltimore	Catonsville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
FIRST MIDDLE LAST CLARENCE MEUSHAU	FIRST MIDDLE LAST SARAH HILL		(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No
16b. SOCIAL SECURITY NO.	17. INFORMANT		17. ADDRESS
212-074448	1222 Tugwell Dr. Catonsville, Md. 21228		1222 Tugwell Dr. Catonsville, Md. 21228
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATHEROSCLEROTIC HEART DISEASE 4140 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) RECTAL TUMOR - COLOSTOMY			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-16-1988 to 3-2-1984 , that (I) (we) lost saw the deceased alive on 3-2-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Sambandam Baskaran	DEGREE M.D.	22c. DATE SIGNED 3-2-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMBANDAM BASKARAN	22e. ADDRESS 3455 WILKENS AVE. BALTIMORE MD 21229		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	March 5, 84	Lakeview Cemetery	Sykesville Carroll Maryland
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		
Ambrose Funeral Home 1328 Sulphur Spring Road	MAR 5 1984		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Jahn</i>	MIDDLE <i>J.</i>	LAST <i>O'Neill</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>3/25/84</i>		2b. HOUR <i>5³⁰ A.M.</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov 22, 1914</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Parkville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Perring Parkway Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Supervisor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Beth Steel</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Parkville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>3022 Acton Rd 21234</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Hugh O'Neill</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Dunphy</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW 11</i>		17. INFORMANT <i>Mrs Anna M O'Neill</i>		ADDRESS <i>Same As 13e</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Aspiration</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral Metastases from Oat Cell CA of Lung</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one week</i> <i>three weeks</i> <i>4 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>None</i>									
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHERE AT WORK <input type="checkbox"/> NOT WHERE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>January 5, 19 84</i> , to <i>March 25, 19 84</i> , that (1) (we) lost saw the deceased alive on <i>March 24, 19 84</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>F. Wiegmann MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>3/26/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>F. WIEGMANN</i>				22e. ADDRESS <i>8406 HARFORD RD. BALTO MD. 21234</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/28/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Leonard J Ruck Inc. Baltimore, Maryland</i>				ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>MAR 28 1984</i>			
						25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

RECEIVED

PRELIMINARY

20% COLLISION



APR 28 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical certificate must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Benjamin F. Outten Jr.				2a. DATE OF DEATH MONTH DAY YEAR 3-14-84		2b. HOUR 9:03am	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 02 21 1923		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 61	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Trappe Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman and		12b. KIND OF BUSINESS OR INDUSTRY farmer	
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Trappe		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Rt 2 Box 118 B 21673		14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Franklin Outten		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Moore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-14-9301		17. INFORMANT ADDRESS Alice M. Outten Item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 7991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from 3-10 to 3-14 , 19 84 , that (X) (we) last saw the deceased alive on 3-14 , 19 84 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (X) (not) view the body after death.							
22b. SIGNATURE Maurice B. Furlong				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maurice B. Furlong, M.D.				22e. ADDRESS 7620 York Road towson Md 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 3/17/84		23c. NAME OF CEMETERY OR CREMATORY DOR. MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CAMBRIDGE DOR. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS THOMAS FUNERAL HOME CAMBRIDGE				25a. DATE REC'D. BY REGISTRAR MAR 23 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lucille M Pacy			2a. DATE OF DEATH MONTH DAY YEAR 3-31-84			2b. HOUR 6:30 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR AUG. 2, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mann Care - Towson				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1725 Lynncrest Rd. 21093	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel J. McGonigle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Newman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Amelia P. Benson		ADDRESS 1725 Lynncrest Rd. 21093			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/14 19 77 , to 3/31 19 84 , that (I) (we) last saw the deceased alive on 3/31 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Walter J. Kees				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter J. Kees				22e. ADDRESS Monkton, Md 21111					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 13, '84		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., MD			
24. FUNERAL DIRECTOR NAME William E. Johnson				ADDRESS 8521 Loch Raven Blvd.		25. DATE REC'D. BY REGISTRAR APR 2 - 1984 REGISTRAR'S SIGNATURE Jana Harrison			

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20% COTTON

CHILL MARK



[Faint, mostly illegible text and markings are visible across the page, including what appears to be a date '1914' and various handwritten notes.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HERMAN ELLSWORTH PAINTER						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3 7 19 84		2b. HOUR 21 30			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 7 27	6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD 3 7 19 84		2d. HOUR 23 30			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 332 Sassafras Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber-Dundalk		12b. KIND OF BUSINESS OR INDUSTRY Plumbing				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 332 Sassafras Road 21221			
14. FATHER'S NAME FIRST MIDDLE LAST Albert V. Painter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanette Beverly				16. ADDRESS 318 St. Georges Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 217-22-0093		17. INFORMANT Herman F. Painter Balto., MD 21221					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c).) PART I DEATH WAS CAUSED BY: 9551 Self inflicted shot gun wound of head IMMEDIATE CAUSE (a) Self inflicted shot gun wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Home DUE TO, OR AS A CONSEQUENCE OF (c) Home									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2130 P.M. 3 7 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self inflicted shot gun wound						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 332 Sassafras Rd. Balt., Md. 21221						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE J. Crossan O'Donovan			M.D. Deputy		MEDICAL EXAMINER			DATE SIGNED 3/7/84			
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN			ADDRESS 2112 Dundalk Ave. Balt., Md. 21222								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/9/1984		23c. NAME OF CEMETERY OR CREMATORY Holly Hill			23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh Maryland				
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.					25a. DATE REC'D. BY REGISTRAR MAR 9 1984		25b. REGISTRAR'S SIGNATURE [Signature]				
7922 Wise Avenue Dundalk, MD. 21222											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

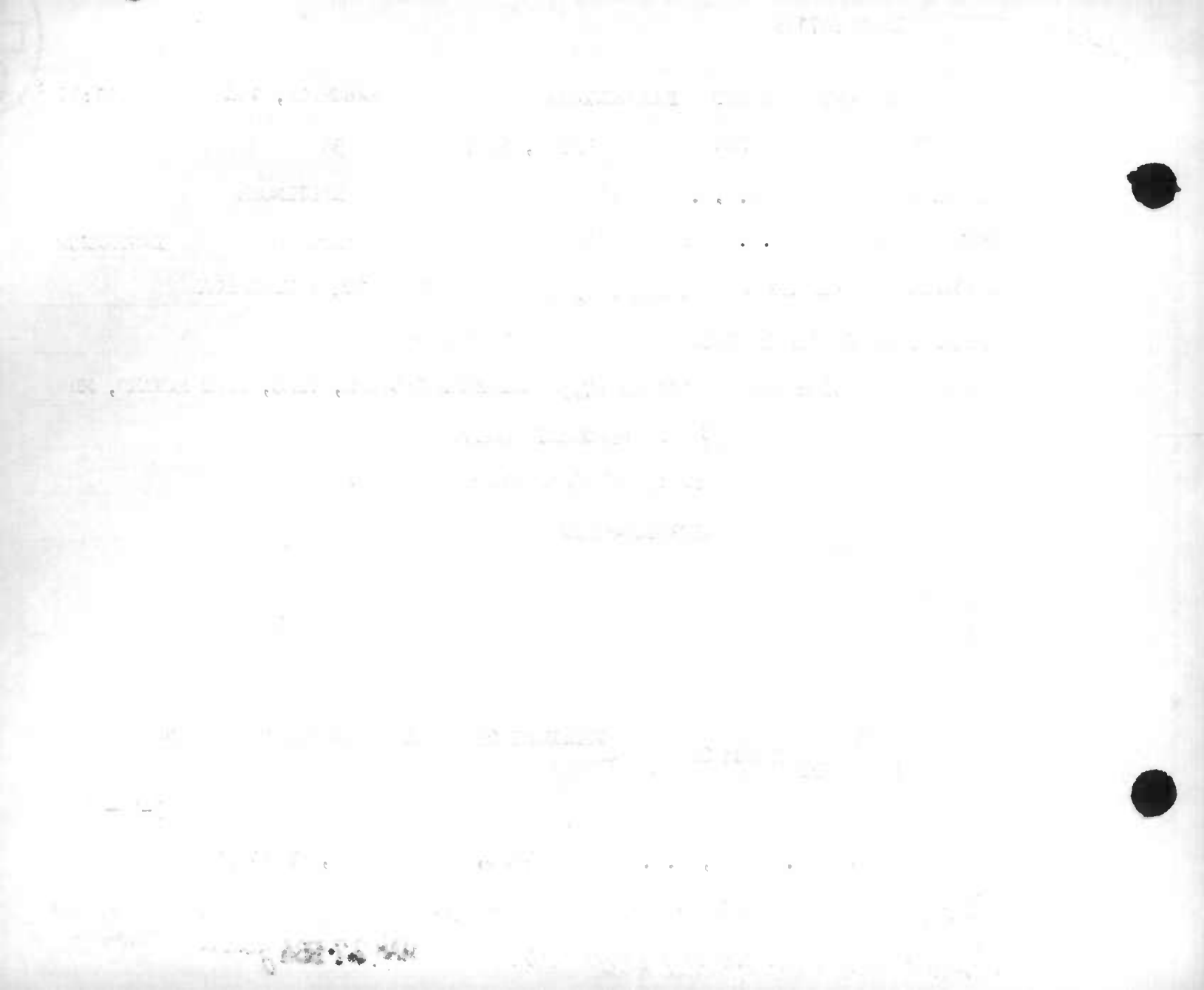
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY LEWIS PAPATONIOUS			2a. DATE OF DEATH MONTH DAY YEAR MARCH 24, 1984		2b. HOUR 11:30 P M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 6, 1947		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 11. STATE MARYLAND			13a. COUNTY BALTIMORE	13b. CITY OR TOWN MIDDLE RIVER	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL LEWIS PAPATONIOUS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES VIET NAM		16b. SOCIAL SECURITY NO. 212 46 5795		17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3440 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE RENAL DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) QUADRIPARESIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from FEBRUARY 29, 1984 to MARCH 24, 1984 , that (X) (we) lost saw the deceased alive on MARCH 24, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Manoranjan P. Singh</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-25-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANORANJAN P. SINGH, M.D.		22e. ADDRESS VAMC, FORT HOWARD, MD 21052			
23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL	23b. DATE 3/27/1984	23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK	23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MD		
24. FUNERAL DIRECTOR NAME ADDRESS R.L. KACZOROWSKI 2525 FLEET ST.		25a. DATE REC'D. BY REGISTRAR MAR 27 1984			

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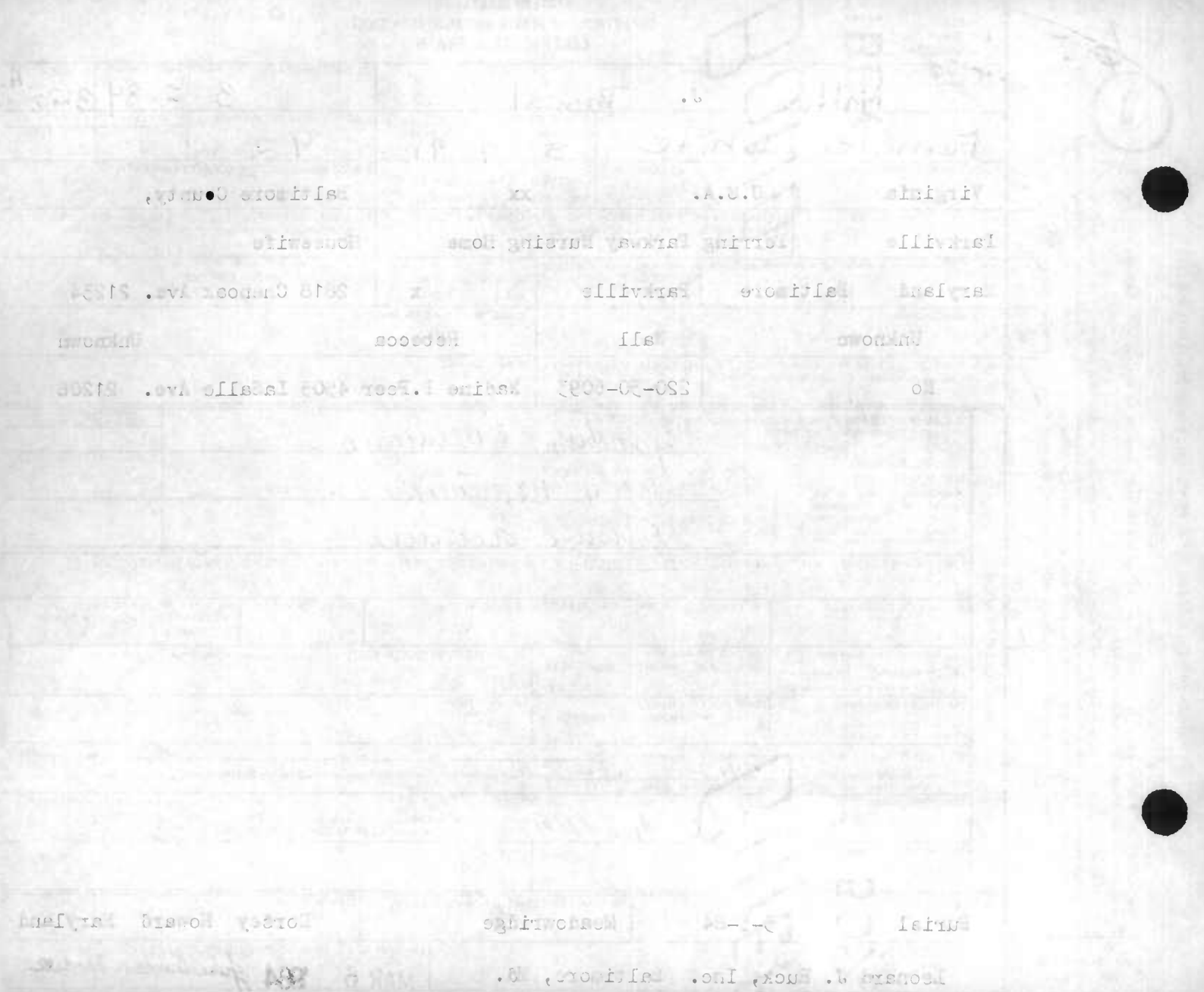
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) Mattie J. Pascal				MONTH 3 DAY 2 YEAR 84			
3. SEX Female				2b. HOUR 3:25 A.M.			
4. RACE White		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
		MONTH 3 DAY 7 YEAR 91		92 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH			
		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore County, MD.			
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perring Parkway Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
FIRST Unknown MIDDLE Wall LAST Wall		FIRST Rebecca MIDDLE Unknown LAST Unknown		2818 Chenoak Ave. 21234			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-30-6093		17. INFORMANT ADDRESS			
				Nadine P. Peer 4505 LaSalle Ave. 21206			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2900 IMMEDIATE CAUSE (a) Aspirin Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Severe Dementia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Arteriosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/17 , 19 84 , to 3-5-84 , that (I) (we) lost saw the deceased alive on 2/17 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Leonard J. Ruck, Inc. DEGREE MD/PA				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3-5-84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION CITY OR TOWN Dorsey Howard COUNTY Maryland STATE Md.	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR MAR 6 1984 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on or before the time of burial or cremation.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Eloise C. PATE			2a. DATE OF DEATH MONTH DAY YEAR March 24 1984		2b. HOUR 4:40 AM	
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Sept 10 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisville Kentucky	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD.		
10. CITY OR TOWN OF DEATH Balto. Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Floral Designer		12b. KIND OF BUSINESS OR INDUSTRY Int. Decorator	
13a. STATE Illinois		13b. COUNTY Mt Prospect	13c. CITY OR TOWN Mt Prospect	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1827 Camp McDonald Rd 60056	
14. FATHER'S NAME FIRST MIDDLE LAST Charles M. Rose		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magdelam Ernstberger		16. ADDRESS 1827 CAMP McDONALD RD MT. PROSPECT ILL.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 403-40-2496		17. INFORMANT WM.E. PATE SR.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor - (Metastatic) 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Large cell Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Large cell Lung Cancer						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Large cell Lung Cancer						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE K. Faulkner MD				22c. DATE SIGNED 3-24-1984		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kendall Faulkner				22e. ADDRESS Towson Md 21204 Stella Maris Hospice		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/29/84		23c. NAME OF CEMETERY OR CREMATORY CALVARY CEM		23d. LOCATION CITY OR TOWN COUNTY STATE JEFFERSON COUNTY KY
24. FUNERAL DIRECTOR NAME JOHN M WEBER		24b. ADDRESS 401 S. CHESTER ST		25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE John M. Weber

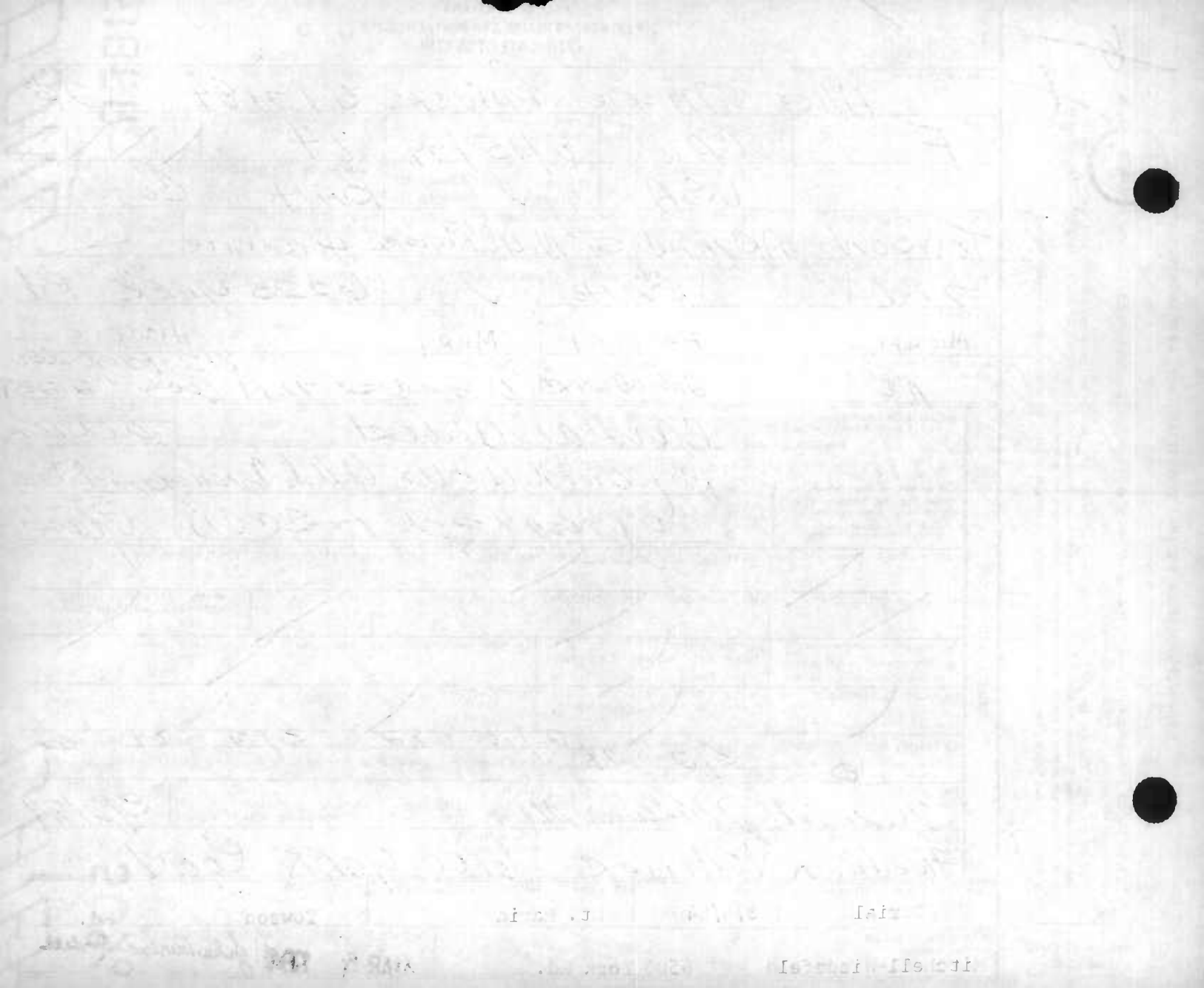
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. FOR STATE REGISTRAR								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alice Marie Patucas</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>3/2/84</i>			2b. HOUR <i>2 P.M.</i>
2. SEX <i>F</i>	4. RACE <i>CAU</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8/15/199</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>TOWSON</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO Co.</i> MD.		
10. CITY OR TOWN OF DEATH <i>TOWSON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ARMACOST N.H. Rego</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>			13b. COUNTY <i>V</i>	13c. CITY OR TOWN <i>BALTO</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6225 York Rd 21201</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>MICHAEL HANDLEY</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY HIGGINS</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>N/O</i>			16b. SOCIAL SECURITY NO. <i>213-03-2443</i>		17. INFORMANT ADDRESS <i>812 Register Ave 21239</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>4413</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Due to, or as a consequence of, Ruptured Aortic Aneurysm 8 hrs</i> (c) <i>Due to, or as a consequence of, Generalized ASCVD</i> <i>5+</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. ANATOMY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I (this hospital) attended the deceased from <i>12/10</i> 19 <i>82</i> to <i>3/2</i> 19 <i>84</i> , that I (we) last saw the deceased alive on <i>3/2</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Frederick Vollmer M.D.</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/2/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Frederick Vollmer</i>					22e. ADDRESS <i>6100 York Road</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>3/6/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Maria</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Towson Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Mitchell-Wiedefeld</i>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>MAR 6 1984 Julia Davidson-Rendell</i>			
ADDRESS <i>6500 York Rd.</i>								



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06445

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence ELIZABETH PAYNE			2a. DATE OF DEATH MONTH DAY YEAR March 30, 1984		2b. HOUR 11:15am M		
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Sewage Disposal	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Harford Joppa				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1129 Clayton Road 21085	
14. FATHER'S NAME FIRST MIDDLE LAST Sidney Houston Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Marie Cottrill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Md. 21047 Paul J. Payne, 2600 Pleasantville Rd. Fallston			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Breast Carcinoma PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 27, 1984, to March 30, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 30, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <input checked="" type="checkbox"/> Myo Thant, M.D.		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-30-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Myo Thant, M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 2, 1984		23c. NAME OF CEMETERY OR CREMATORY Highview Memorial Gardens, Fallston		23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.	
24. FUNERAL DIRECTOR H. K. McCOMAS III, Arlington, Md. 21009				25a. DATE REC'D. BY REGISTRAR APR 2 - 1984			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

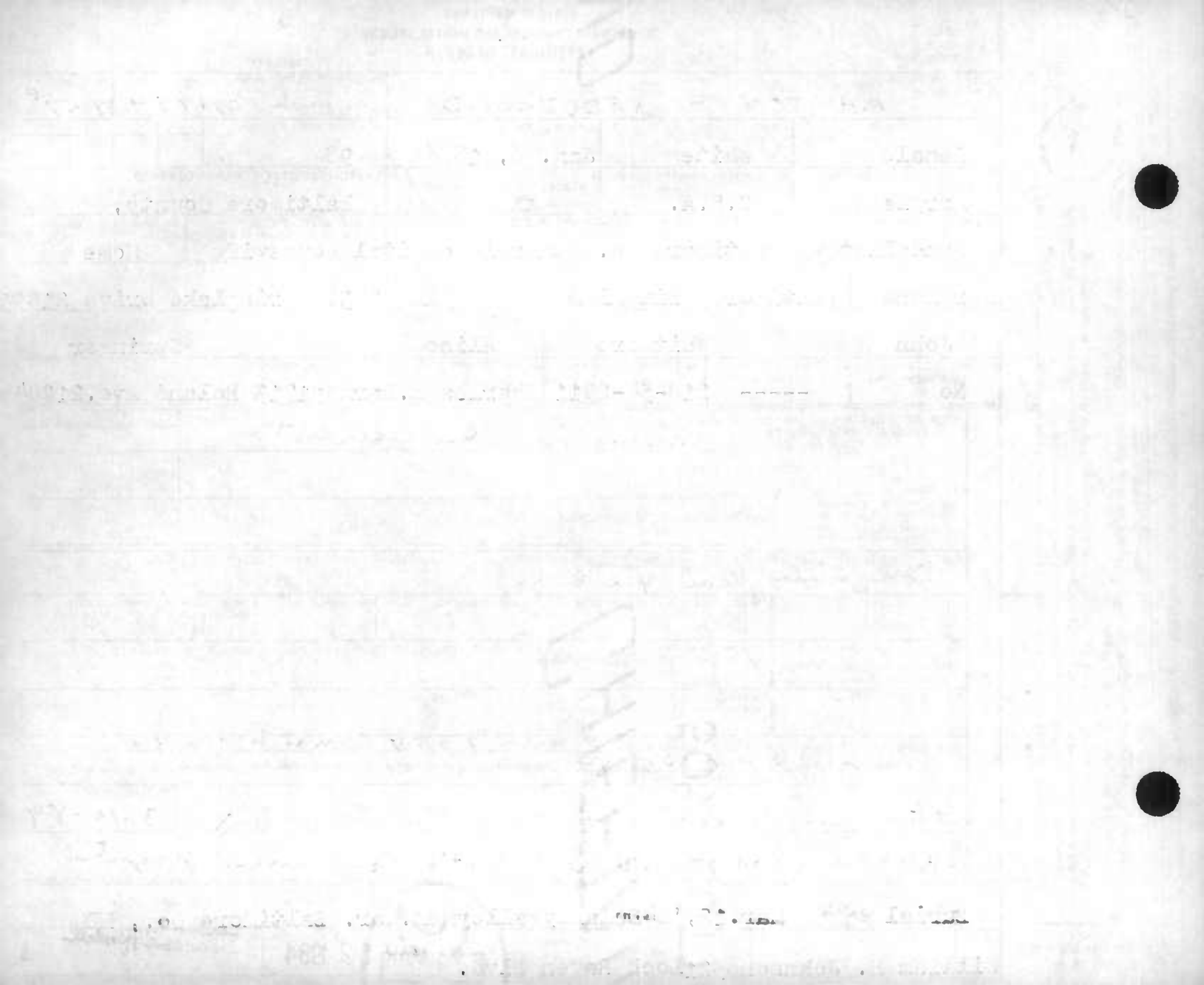
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
MARION - PEDDICORD		March 10, 1984		7:55 P		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female	White	Jan. 6, 1886		98 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.			Baltimore County, MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Randallstown	Baltimore Co. General Hospital		Housewife		Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Baltimore		Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
John		Alice		2438 Springlake Drive 21093			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		218-54-2911		Charles E. Darney 1713 Roland Ave. 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Congestive Heart Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 9, 1984</u> to <u>March 10, 1984</u> , that (I) (we) last saw the deceased alive on <u>March 10, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sharon D. Pourmotabbed, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-10-84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHASSEM POURMOTABBED		22e. ADDRESS Balt. Co. General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Mar. 12, '84		Dulaney Valley Mem. Gar.		Baltimore Co., MD	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William E. Johnson		MAR 12 1984		<u>na Davidson</u>			
25c. ADDRESS		8521 Loch Raven Blvd.					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of choice.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

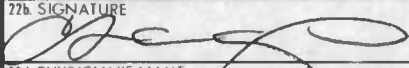
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted after completion of this certificate.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY L. PEELING			2a. DATE OF DEATH MONTH DAY YEAR 3/2/84			2b. HOUR 3:44 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 11, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hanover Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N. CHARLES ST. GBMC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian for Balto. Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1012 Nicodemus Rd. 21136	
14. FATHER'S NAME FIRST MIDDLE LAST Albert S. Lawyer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hooper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 217-28-5309		17. INFORMANT ADDRESS Mr. J. Edward Peeling Reisterstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CENTRAL NERVOUS SYSTEM DISEASE (c) METASTATIC BREAST CANCER								2 WEEKS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/21/84 to 3/2/84 , that (I) (we) last saw the deceased alive on 3/2/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE MD				22c. DATE SIGNED 3-2-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. C. CUMMINGS				22e. ADDRESS GBMC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/5/84		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster, Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home Reisterstown, Md.				25a. DATE REC'D. BY REGISTRAR MAR 5 1984					

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NO. 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ELIZABETH		B.		PERRY				3		25	84	10:55p _M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS			
F		W		Sept. 2, 1911		72		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Va.		USA				BALTIMORE COUNTY MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		GREATER BALTIMORE MEDICAL CENTER								Homemaker			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Md.		Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		200 Overbrook Road 21212					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Charles Bodley				Selina Jones									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				197-05-2563		Mr. George E. Perry, Jr. 200 Overbrook Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION													
4100													
DUE TO, OR AS A CONSEQUENCE OF													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK													
22a. I certify that (I) (this hospital) attended the deceased from 3/19, 19 84, to 3/25, 19 84, that (I) (we) last saw the deceased alive on 3/26, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								DEGREE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
Ronald L. Sirota, M.D.													
22e. ADDRESS													
6701 N. Charles St., Baltimore, MD 21204													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				3/29/84		Parkwood Cemetery		Baltimore, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.								MAR 30 1984		Julia Davidson-Rondell			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06449

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARTHA H. PETERS			2a. DATE OF DEATH MONTH DAY YEAR MARCH 10, 1984			2b. HOUR 1:40 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 26 10		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) KEY PUNCH OPER		12b. KIND OF BUSINESS OR INDUSTRY BENDIX	
13a. STATE MARYLAND					13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 8713 SUMMIT AVE 21237		
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT JACOT					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE GROSJEAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 313-20-5204		17. INFORMANT ADDRESS FAMILY RECORDS		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4850 BRONCHOPNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) _____			
DUE TO, OR AS A CONSEQUENCE OF (b) _____			
DUE TO, OR AS A CONSEQUENCE OF (c) _____			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) EMATIATION DUE TO MALNUTRITION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE REYNALDO ORJUELA-GOMEZ, M.D.				DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) REYNALDO ORJUELA-GOMEZ, M.D.				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-13-84		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PK. BALTO. COUNTY		23d. LOCATION CITY OR TOWN COUNTY STATE MD.	
24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMORIES 8800 HARFORD				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 15 1984 Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06450

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARGARET MIDDLE Isabelle LAST Pfoutz <i>MARGARET Pfoutz</i>			2a. DATE OF DEATH MONTH DAY YEAR 3-24-84			2b. HOUR 8:28 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 8, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 7 Lentmill Lane 21208			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13f. STREET ADDRESS			
14. FATHER'S NAME FIRST Edward MIDDLE Lescalleet LAST			15. MOTHER'S MAIDEN NAME FIRST Clara MIDDLE Paine LAST			16. ADDRESS 122 Dunkirk Rd. Baltimore, Md. 21212			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-22-4491		17. INFORMANT Warren J. Pfoutz				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO-RESPIRATORY ARREST</i> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute MYOCARDIAL INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Anemia</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-12</i> , 19 <i>84</i> , to <i>3-24</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>3-24</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-24-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. CONAWAY MD			22e. ADDRESS BCGH - RANDALLSTOWN Md. 21133						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 27, 1984		23c. NAME OF CEMETERY OR CREMATORY Pipe Creek		23d. LOCATION CITY OR TOWN COUNTY STATE Union Bridge, Carroll Co., Md.		
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212			ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 27 1984 <i>[Signature]</i>				

BP

1901-1902

1900

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06451

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST Joseph PIEKARSKI Sr.			2a. DATE OF DEATH MONTH DAY YEAR March 6, 1984			2b. HOUR 10:25am	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 02 13 09		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GUARD		12b. KIND OF BUSINESS OR INDUSTRY MANUFACTURE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN ROSEDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1312 CHAPEL HILL DRIVE 21237							
14. FATHER'S NAME FIRST MIDDLE LAST MATTHEW PIEKARSKI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALEXANDRA ZALEWSKI			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214018977		17. INFORMANT ADDRESS HELEN PIEKARSKI 1312 CHAPEL HILL DR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4273 IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) chronic atrial fibrillation associated with unknown cardiac disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/6 , 19 84 , to 3/6 , 19 84 , that (I) (we) last saw the deceased alive on 3/6 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>David Walford</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/6/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. David Walford		22e. ADDRESS 9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/9/84		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMET.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO BALTO MD.	
24. FUNERAL DIRECTOR <i>W. J. Walford</i>		ADDRESS 1211 Chesapeake Ave.		25a. DATE REC'D. BY REGISTRAR MAR 7 1984			
25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>							

NAME LAST FIRST MIDDLE (Print Name)		GRADE (Print Grade)	
ADDRESS STREET CITY STATE ZIP (Print Address)		SCHOOL (Print School Name)	
DATE MONTH DAY YEAR (Print Date)		SIGNATURE (Print Signature)	
PARENTS FATHER MOTHER (Print Names)		TEACHER (Print Name)	
COMMENTS (Print Comments)		REMARKS (Print Remarks)	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06452

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERTA C. POHMER			2a. DATE OF DEATH MONTH DAY YEAR March 23, 1984		2b. HOUR M M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 6 00		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Towson Baltimore County MD.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Multi Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wilson Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Quelet					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-36-2943 A		17. INFORMANT ADDRESS Milton Kelman 8542 Stevenswood Road 21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4292 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 10 yr								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) urinary tract infection								
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6/7 19 83 to 3/22 19 84 , that (I) (we) last saw the deceased alive on 3/22 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Maurice Feldman M.D.				DEGREE M.D.		22c. DATE SIGNED 3/23/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maurice Feldman, Jr. M.D.				22e. ADDRESS 6610 Cross Country Blvd.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 3-26-1984		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR Ruck Towson Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE POLAN			2a. DATE OF DEATH MONTH DAY YEAR MARCH 12, 1984		2b. HOUR 6:00 p.m.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 15, 1906	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH PIKESVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MILFORD MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7616 CARLA RD. 21208	
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN BECKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST YETTA KATZOFF				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-50-6893		17. INFORMANT ADDRESS MRS. CELESTE FAIRBUSH 825 SMOKETREE RD. #21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiogenic shock</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MI acute</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Severe Dementia</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <u>MR</u> (his hospital) attended the deceased from <u>11-12-81</u> to <u>3-13-84</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>2-28-84</u> , 19 <u>84</u> , and that in my <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did not)</u> view the body after death.						
22b. SIGNATURE <u>Dr. Barry Gold</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-13-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BARRY GOLD		22e. ADDRESS 6804 PARK HEIGHTS AVE.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/14/84		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215				25a. DATE REC'D. BY REGISTRAR MAR 16 1984		
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>MARIA D PORTER</i>				2b. HOUR <i>6:54 P</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 10 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Joseph's Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Balto. County</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Casper Kraft</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lena Punte</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>218-26-7598</i>	
17. INFORMANT <i>Dolores A. Butt</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic CARDIOVASCULAR DISEASE</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED <i>3/6/84</i>	
22b. SIGNATURE <i>Barry Josephs</i>		22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Barry Josephs MD</i>		22e. ADDRESS <i>St. Joseph's Hospital, Balto., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-10-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Lassahn Funeral Home</i>		24b. ADDRESS <i>7401 Belair Rd. Balto., Md. 21236</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 14 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06455

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mrs. Rhoda Price		2a. DATE OF DEATH MONTH DAY YEAR March 24 1984		2b. HOUR 8:30 A	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 4 1891		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Pikesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pikesville Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5343 Maple Ave. 21215	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Funkhouser		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dicie Ryan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 219-36-0702		17. INFORMANT ADDRESS Mrs. Helen Zirkle Rt. 2 Box 776 King George Virginia	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4360

IMMEDIATE CAUSE (a)

Stroke (cerebrovascular accident)APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**Acute**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/21 , 19 83 , to 3/24 , 19 84 , that (I) (we) lost saw the deceased alive on 3/23 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)			
22b. SIGNATURE Harold B. Bob	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/24/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold B. Bob		22e. ADDRESS 7220 Park Heights 21208	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial	23b. DATE 3/24, 1984	23c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran Ch.	23d. LOCATION CITY OR TOWN COUNTY STATE Edinburg Shenandoah Virginia
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.		25a. DATE REC'D. BY REGISTRAR MAR 27 1984	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			
2728 Liberty Road Randallstown, Maryland 21133			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06456
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Lenore A. Rach</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3-6-84</i>			2b. HOUR <i>5:15 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7-17-22</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>61</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wisconsin</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1327 Heatherhill Rd. -21239</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bookkeeper</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Jenkins Jewelers</i>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Baltimore</i>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1327 Heatherhill Rd. -21239</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>Frederick Cassens</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Amanda Giesse</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO <i>389-14-0256</i>		17. INFORMANT ADDRESS <i>John W. Rach - 1327 Heatherhill Rd. -21239</i>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Myeloma</i> <i>2030</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Thrombocytopenia</i> (c) <i>Bone Marrow Failure</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>— — — — —</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>—</i> , 19 <i>—</i> , to <i>—</i> , 19 <i>—</i> , that (I) (we) lost saw the deceased alive on <i>—</i> , 19 <i>—</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Don W. Miller</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/8/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Don W. Miller</i>		22e. ADDRESS <i>M. WITZEN 3009 EVERGREEN AVE BALTIMORE MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-9-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc-6415 Belair Rd. -21206</i>				25. DATE REC'D. BY REGISTRAR <i>MAR 13 1984</i>			
25b. REGISTRAR'S SIGNATURE <i>Davidson-Winnell</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonoppers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carroll Benjamin REED					2a. DATE OF DEATH MONTH DAY YEAR March 21, 1984			2b. HOUR 7:05P _M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 22 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Balto., Co.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Dan Reed					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriett Park's				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 1944-1945		17. INFORMANT Margaret Reed		ADDRESS 11529 Eastern Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Squamous Cell Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11c									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from March 7, 1984, to March 21, 1984, that (we) last saw the deceased alive on March 21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did) (we did not) view the body after death.									
22b. SIGNATURE Dr. Kazimierczak					DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Kazimierczak					22e. ADDRESS 9000 Franklin Square Dr., 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/26/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest St. Vet.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS William C. Brown 1206 W. North Ave.					25a. DATE REC'D. BY REGISTRAR MAR 23 1984		25b. REGISTRAR'S SIGNATURE S. J. Gendell		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06453

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JACK EUGENE REED			2a. DATE OF DEATH MONTH DAY YEAR MARCH 18, 1984		2b. HOUR 9:45 P
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 1 25 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.	
10. CITY OR TOWN OF DEATH DUNDALK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 55 DUNDALK AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY CHEMICAL MFGGR.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN DUNDALK	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES M. REED			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIA HESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 176.05.9118		17. INFORMANT ADDRESS ELSIE M. REED (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cor Pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) C.I.D.P.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept 27, 1975, to Mar 18, 1984, that (I) (we) last saw the deceased alive on March 18, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Benigno R. Lazano MD		DEGREE		22c. DATE SIGNED 3-19-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENIGNO R. LAZANO MD		22e. ADDRESS 69 Dandallis Rd Balti. Md 21222			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/21/1984		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		23e. DATE REC'D. BY REGISTRAR MAR 19 1984			
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD 21222		25. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.				
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR
1. DECEASED NAME FIRST MIDDLE LAST Dorothy L. REIBER				March 24, 1984				3:15a M
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 6/5/09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE MD.	13b. COUNTY BALTO	13c. CITY OR TOWN ESSEX	13e. STREET ADDRESS / ZIP CODE 906 LUTZ AVE		21221			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN W. PAYNE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY D. BAKER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216 10 6907		17. INFORMANT ADDRESS DORIS KASPA 1634 GAR RD APT. B		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2866 IMMEDIATE CAUSE (a). Cardiac Arrest Massive Upper Gastrointestinal Blood Loss (b). Generalized Gastritis with Probable Disseminated Intravascular Coagulation (c). DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (his hospital) attended the deceased from March 20, 1984, to March 24, 1984, that (I) (we) saw the deceased alive on March 24, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Fernando J. Acle, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fernando J Acle, M.D.				22e. ADDRESS 9000 Franklin Square Drive, 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/27/84		23c. NAME OF CEMETERY OR CREMATORY BALTO. NATL. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
24. FUNERAL DIRECTOR NAME J.G. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 29 1984 John Davidson-Rendell		

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APR 28 1941

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (1))
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Patricia Reiber							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 3/20/84		2b. HOUR 4:45		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1928	6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 3/20/84		2d. HOUR 4:45			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales			12b. KIND OF BUSINESS OR INDUSTRY Movie Theater			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2219 Graythorn Road 21220			
14. FATHER'S NAME FIRST MIDDLE LAST Jay Rhine				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia Raguckas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 213 26 0086		17. INFORMANT ADDRESS Dalton G. Reiber (Husband) Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described HEAD ONLY Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]		TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER						DATE SIGNED 3/21/84			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/23/84		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Garden				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.			
24. FUNERAL DIRECTOR NAME Bruzdzinski Funeral Home				25a. DATE REC'D. BY REGISTRAR MAR 27 1984				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

RECEIVED - COMMUNICATIONS SECTION
U.S. AIR FORCE
WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1- FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Lillian M. Reichart				2a. DATE OF DEATH MONTH DAY YEAR March 1, 1984		2b. HOUR 4:50a_M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 22 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Bromley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances West			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-66-0339		17. INFORMANT 1080 St. Agnes Lane Balto., MD. 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2760 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hyperosmolen State Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF Bilateral pneumonia, Diabetes (c) Dehydration, Urinary Tract Infection, mellitus							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 24 , 19 84 , to March 1 , 19 84 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 1 , 19 84 , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE Daniel M. Jannuzzi				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-1-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) daniel M. Jannuzzi, M.D.				22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/5/1984		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR Duda-Ruck, Inc. NAME ADDRESS 7922 Wise Avenue Dundalk, MD. 21222				25a. DATE REC'D. BY REGISTRAR MAR 6 1984		25b. REGISTRAR'S SIGNATURE Jana Anderson-Randall	

BP

FIGURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) JOAN HARDISH REID					3/22/84							8:50 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 30 1931^{AR}		6. AGE (IN YEARS LAST BIRTHDAY) 52		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.							
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N CHARLES ST GBMC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) R.N.			12b. KIND OF BUSINESS OR INDUSTRY Hospital				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baldwin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4100 Kincaid Road 21013					
14. FATHER'S NAME FIRST MIDDLE LAST George Hardish				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Magdeline Hobbs									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 186-24-5338		17. INFORMANT ADDRESS Mr. J.D. Reid Jr. 4100 Kincaid Road 21013									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) CARDIOPULMANARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE CARDIOMYOPATHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: HE PATORENAL SYNDROME													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 3/15 19 84 to 3/22 19 84 , that (I) (we) lost saw the deceased alive on 3/22 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Dr. T.E. Herlihy</i>				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/22/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR T.E. HERLIHY				22e. ADDRESS GBMC									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-27-84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Baltimore Maryland							
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home ADDRESS 6500 York Road 21212						25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>					

BP _____

3/22/54

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BALTIMORE COUNTY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy be performed.

DHMH - 16 60M 7/73
(VRA 15(4))

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Emanuel M. Reiter		MONTH DAY YEAR MARCH 28, 1984		10:50 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male	White	MONTH DAY YEAR OCT 15 1897		86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Phila. Pa.	USA			Baltimore Co. MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Towson		St. Joseph's Hospital		Consultant	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
13a. STATE COUNTY CITY OR TOWN Md. Balt. Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4820 Charles Valley Way	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Jacob Reiter		FIRST MIDDLE LAST Celia Unk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		136014873		Dorothy L. Reiter Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>MESENTERIC THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>GENERALIZED ASCVD</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u> <u>5+/- YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>2/24</u> 19 <u>84</u> to <u>3/28</u> 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>3/28</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Charles F O'Donnell</u> DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
CHARLES F O'DONNELL MD		7501 York Rd. Towson Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3-30-84		Bnai Abraham Mem. Union	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Hardesty Funeral Home		Annapolis, Md		MAR 29 1984	

BP

March 22, 1951

Generalized Anxiety
Disorder

Ch. 11 - Generalized Anxiety Disorder

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 06464			
1. DECEASED NAME (TYPE OR PRINT) MILDRED E. REITZE				2a. DATE KNOWN OF DEATH 3-8-84 19				2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 7, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 3-8-84 19 3:45P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) York Rd. westbound ramp at #695			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY School Teacher							
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 106 Forest Drive 21228	
14. FATHER'S NAME Joseph				15. MOTHER'S MAIDEN NAME Annie Bowers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-40-5568				17. INFORMANT 14 Tullip Tree Court 21221 Frederick C. Reitze, Jr. - Baltimore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head injuries</u> 8121 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 3:30PM 3-8-84 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger of auto/tractor trailer impact			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.				21f. LOCATION York Rd. Westbound ramp at #695 Balto. Co., Maryland			
22a. I certify that I took charge of the remains described above and an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 3-9-84			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/12/84		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery				23d. LOCATION Pikesville COUNTY STATE Md.	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR MAR 13 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

Memorandum for the Director

Subject: [Illegible]

Reference is made to [Illegible]

On [Illegible] [Illegible]

[Illegible]

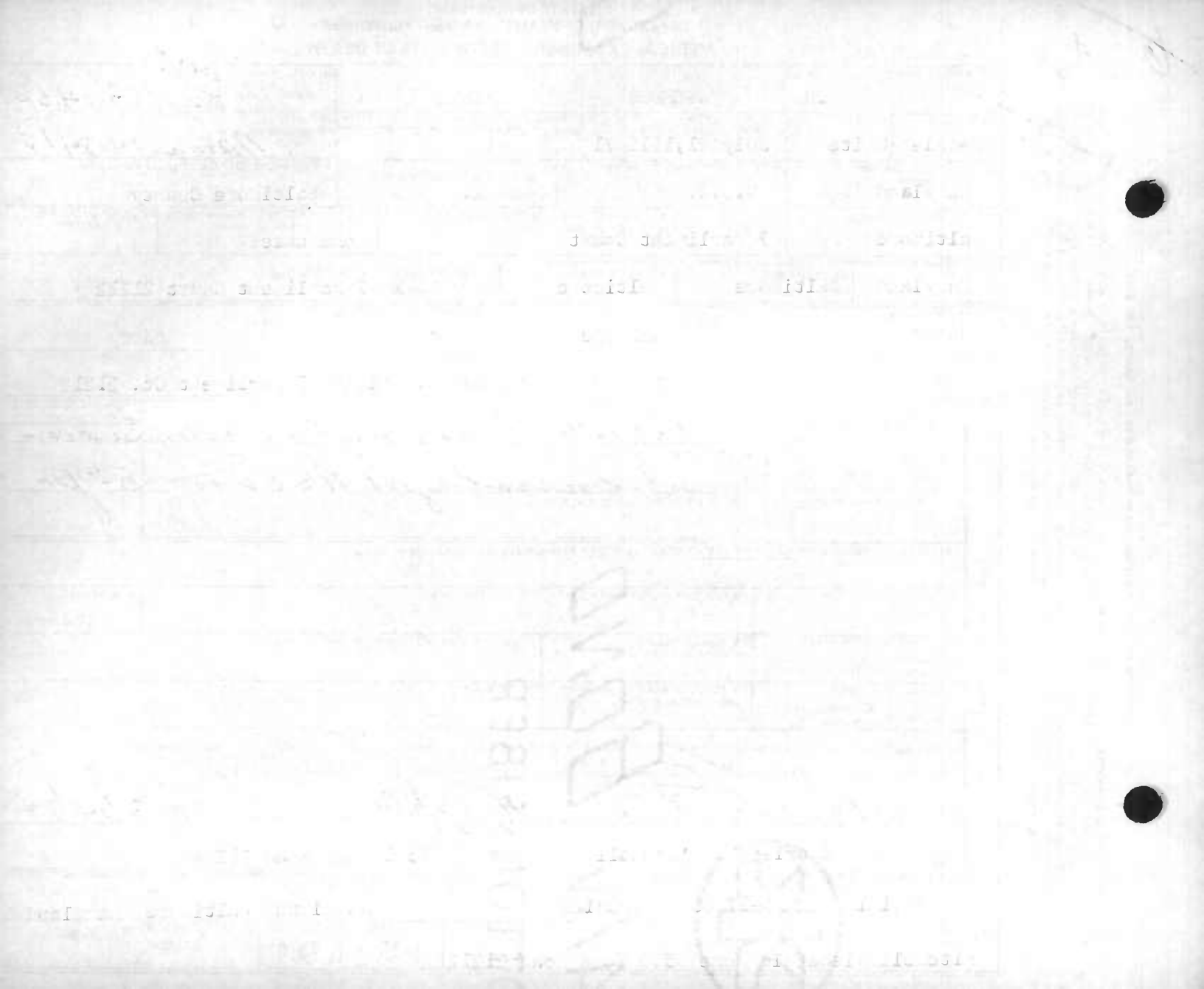
[Illegible]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06465	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH ASHMORE RENNIX										2a. DATE KNOWN OF DEATH MONTH DAY YEAR March 13, 1984	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 21, 1912		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 71		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7 Parllment Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7 Parllment Court 21212			
14. FATHER'S NAME FIRST MIDDLE LAST Darby Ashmore						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Barry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-10-7153		17. INFORMANT ADDRESS Dawn A. Rairigh 7 Parllment Ct. 21212					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100 Acute Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Generalized ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5+ yrs</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER		DATE SIGNED <u>3/14/84</u>	
EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell				ADDRESS 7501 York Road 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-17-83		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home						ADDRESS 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR MAR 16 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2b. HOUR				
FIRST MIDDLE LAST					MONTH DAY YEAR				
SIDNEY O. RHOTEN					3 19 84 10 A.M.				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
Male		White		MONTH DAY YEAR		90 YRS.		MONTHS DAYS HOURS MIN.	
9 25 1893		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.						Baltimore County MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Monkton		16918 York Road		Maintenance		Beth. Steel			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE					13b. STREET ADDRESS				
Maryland					17215 Prettyboy Dam Road				
13c. COUNTY					21120				
Baltimore					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13c. CITY OR TOWN									
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Daniel W. Rhoten					Mary Katherine Rote				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
No					213-09-0810				
17 INFORMANT					909 BEAVERBANK CIRCLE				
					Charles S. Rhoten Balto., MD. 21204				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a)					Myocardial infarction				
4100					5 min				
DUE TO, OR AS A CONSEQUENCE OF					Ischemic heart disease				
(b)					10 yrs.				
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
diabetes mellitus									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY				
					HOUR A.M. MONTH DAY YEAR				
					P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
21f. LOCATION					CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/23/84 to 3/19/84, that (I) (we) last saw the deceased alive on 3/19/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE				
Mark S Kaplan					MD				
22c. PHYSICIAN'S NAME (TYPE OR PRINT)					22d. ADDRESS				
MARK S KAPLAN MD					16918 YORK RD MONKTON MD.				
22e. DATE SIGNED									
3/19/84									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE				
Burial					3/21/84				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION				
Dover Church Cem.					CITY OR TOWN COUNTY STATE				
					Baltimore MD.				
24 FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR				
Duda-Ruck, Inc.					MAR 22 1984				
NAME					25b. REGISTRAR'S SIGNATURE				
7922 Wise Avenue Dundalk, MD. 21222					Julia Davidson-Randall				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, no autopsy, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Leva Ellen Riddle					2a. DATE OF DEATH MONTH DAY YEAR 3- 31- 84 2b. HOUR 8:20p M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05 21 1886		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
12. CITY OR TOWN OF DEATH Catonsville		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 117 S. Rolling Rd.				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		15. KIND OF BUSINESS OR INDUSTRY Home		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE MD.					17b. COUNTY Baltimore		17c. CITY OR TOWN Catonsville		17d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. FATHER'S NAME FIRST MIDDLE LAST Harmon Workman					19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Unknown					
20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		20b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233 96 6089		21. INFORMANT ADDRESS Sarah R. McCorkle 117 S. Rolling Rd. 21228						
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ASCVD - Hypertension</u></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-1 day</p>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>82</u> to <u>Feb</u> 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>Feb-16</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Alexander M. M. M. M.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alexander M. M. M. M.					22e. ADDRESS 1900 Sulphur Spring Rd Balto 21227.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-4-84		23c. NAME OF CEMETERY OR CREMATORY Docks Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kenova Wayne W.VA.				
24. FUNERAL DIRECTOR NAME LeRoy M. & Russell C. Witzke Catonsville, MD.					25a. DATE REC'D. BY REGISTRAR APR 3 1984		25b. REGISTRAR'S SIGNATURE <u>Russell C. Witzke</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Henry Lawrence RIDGELY			2a. DATE OF DEATH MONTH DAY YEAR March 12, 1984		2b. HOUR MIN. 12:15pm	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1-13-1943		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.		
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSP.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.		13b. CITY OR TOWN BALTO.		13c. STREET ADDRESS 9535 BURTON AVE.		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN H. RIDGELY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE JOHNSON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINE REPAIR.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 214-40-8532		17. INFORMANT ADDRESS Mrs. Dora D. Ridgely - 9535 Burton Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 4300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subarachnoid Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (if in this hospital) attended the deceased from March 1, 1984 to March 12, 1984 , that (if we) lost saw the deceased alive on March 12, 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (do not) view the body after death.						
22b. SIGNATURE H. Montandon MD		DEGREE		22c. DATE SIGNED 3-12-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Montandon, M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-14-84		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD AVE.		
24. FUNERAL DIRECTOR NAME Paul H. Hill		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		25. DATE REC'D BY REGISTRAR MAR 13 1984		

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U.S.A.

1-13-1943

14

DATE

FRANKLIN SQUARE #107

NO

DATE

1532 GURTON AVE

JOHN H. RIDLEY

JEANIE JOHNSON

YES

11-10-1943

CHILDREN

20% COTTON



BURIAL

3-14-84

THICKWOOD AVE

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lawrence T Ritter			2a. DATE OF DEATH MONTH DAY YEAR 3 6 84			2b. HOUR 8:12 ^A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 04 00		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired- Farmer	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville	
14. FATHER'S NAME FIRST MIDDLE LAST E. Frank Ritter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary J. Townsend			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-38-4291		17. INFORMANT Mr. Raymond E. Ritter ADDRESS 7501 Inwood Road Catonsville, Md. 21228			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4241

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Acute Seniors, Aged

DUE TO, OR AS A CONSEQUENCE OF

(c)

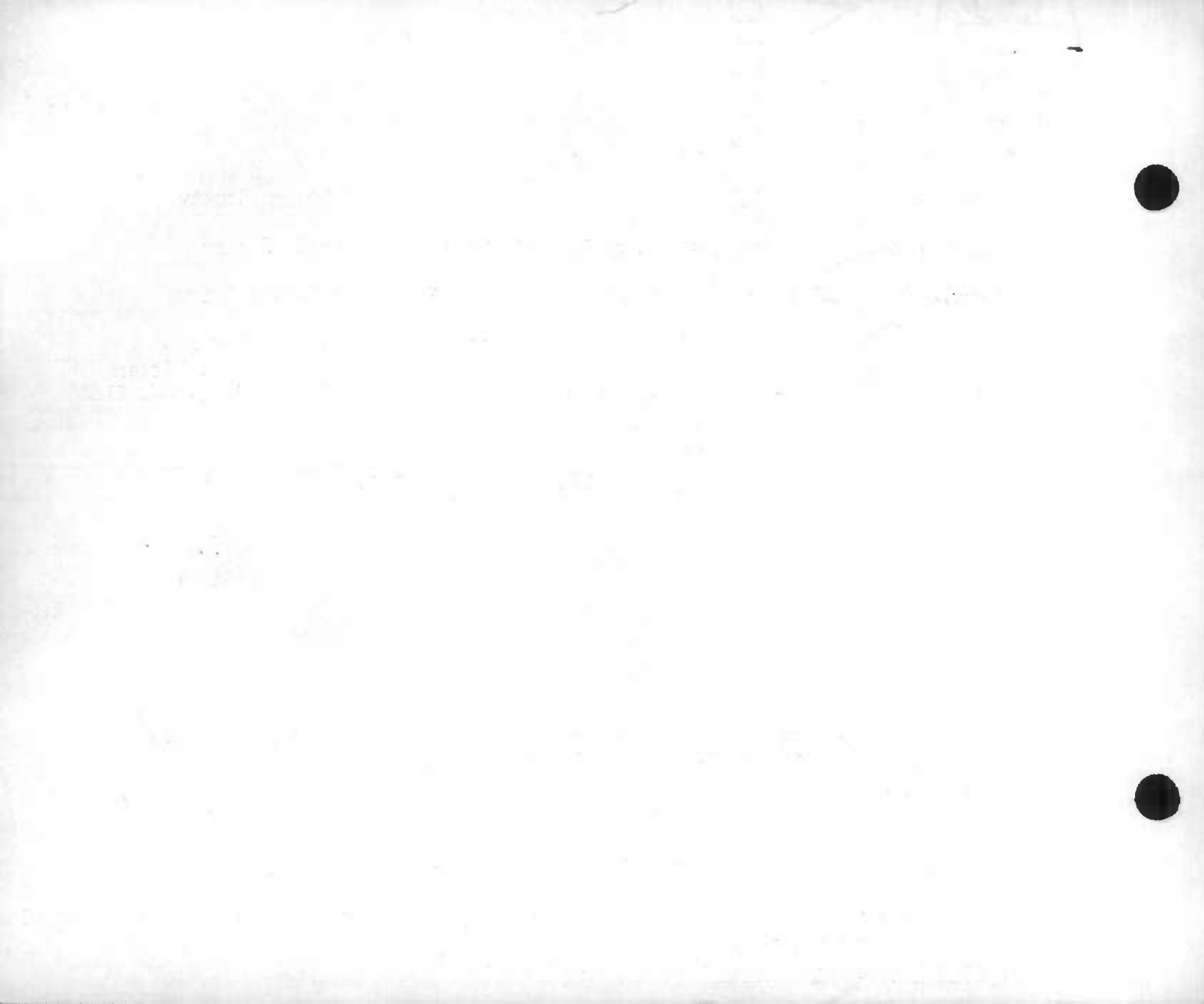
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-6 19 84, to 3-6 19 84, that (I) (we) lost the deceased alive on 3-6 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)							
22b. SIGNATURE G. Warfor		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/6/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. MARFORI		22e. ADDRESS 3401 Old County Road Randalltown, Md. 21133					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-9-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133				25a. DATE REC'D. BY REGISTRAR MAR 9 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06470

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HAROLD E. ROBERTS			2a. DATE OF DEATH MONTH DAY YEAR 3 27 '84			2b. HOUR 7:00A M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 5, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMP.		12b. KIND OF BUSINESS OR INDUSTRY CARPENTER	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2341 YORK ROAD 21093		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ROBERTS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. 218 05 1681		17. INFORMANT ADDRESS FAMILY RECORDS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **SEPSIS****5728**

DUE TO, OR AS A CONSEQUENCE OF

(b) **TERMINAL LIVER FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 3/21/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FEEDING JEJUNOSTOMY EXPLORATION RELEASE OF ADHESION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/26 , 19 84 , to 3/27 , 19 84 , that (I) (we) last saw the deceased alive on 3/27 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert L. Smith MD				DEGREE		22c. DATE SIGNED 3-27-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. SMITH, M.D.				22e. ADDRESS GBMC - 6701 N. CHARLES STREET 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-30-1984		23c. NAME OF CEMETERY OR CREMATORY MAYS CHAPEL Cem TOWSON		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF CHIMES 2325 YORK ROAD				25a. DATE REC'D BY REGISTRAR MAR 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," the attending physician must specify the nature of the injury, or other traumatic event, the medical examiner must be notified of once.

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HAROLD

ROBERTS

3 27' 00" 7:00A

MALE

BALTIMORE COUNTY

6BMC-2701 N. CHARLES ST.

TOWSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Clarence P. ROBINSON						2a. DATE OF DEATH MONTH DAY YEAR March 2, 1984			2b. HOUR 3:50 ^a M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 17 21		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Balto. County		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13e. STREET ADDRESS / ZIP CODE 819 Martin Road 21221					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 241-26-8746			17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Refractory Ventricular Tachycardia 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Presumed Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE BY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that X (this hospital) attended the deceased from March 2, 1984, to March 2, 1984, that X (we) lost saw the deceased alive on March 2, 1984, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE Mark Lans Frydenborg MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/2/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Lans Frydenborg, M.D.						22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 3/1 3/5/84			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.			25a. DATE REC'D. BY REGISTRAR MAR 12 1984		
						25b. REGISTRAR'S SIGNATURE [Signature]					

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MAMIE VIOLA ROBINSON				2a. DATE OF DEATH MONTH DAY YEAR March 4, 1984		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 30, 1902		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		
10. CITY OR TOWN OF DEATH Lansdowne		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 202 Hillendale Ave.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY May Co.				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lansdowne		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 202 Hillendale Ave. 21227				
14. FATHER'S NAME FIRST MIDDLE LAST John Knauff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Keffer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-07-9722		17. INFORMANT (son) ADDRESS Mr. Robert R. Wilson Severn, Md. 21144		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial infarction (c) Atherosclerotic CVD					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/11 19 15		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3/2 19 84 to 3/4 19 84 , that (II) (we) lost saw the deceased alive on 3/2 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Herbert J. Levickas		DEGREE MD		22c. DATE SIGNED 3/6/84		
22d. PHYSICIAN'S NAME (PRINT NAME) Dr. Herbert J. Levickas		22e. ADDRESS 5404 East Dr. Arbutus, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 7, 1984		23c. NAME OF CEMETERY OR CREMATORY Freedom Meth. Cem. Eldersburg Carroll Md.		
23d. FUNERAL DIRECTOR (NAME) Singleton Funeral Home, Glen Burnie, Md.		23e. ADDRESS 4100		23f. DATE REC'D. BY REGISTRAR MAR 6 1984		
23g. REGISTRAR'S SIGNATURE John Davidson-Randall						

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM VM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME FIRST MIDDLE LAST PRITZ CALVIN ROBISIN										March 9 1984 6P	
3 SEX M	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 01 07 40	6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD		March 9 1984 6P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U/S		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21214 1102 Meridene Rd. Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Leonard Robbie Robisin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie Marie Brown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Leonard Robisin - Same as #13.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction Sudden DUE TO, OR AS A CONSEQUENCE OF Generalized ASCVD (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 1/2 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Deputy			TITLE (SPECIFY) Deputy				MEDICAL EXAMINER		DATE SIGNED 3/10/84		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 3/11/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAR 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

BALTIMORE COUNTY

BALTIMORE ST JOSEPH HOSPITAL

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ROBINSON

CALVIN

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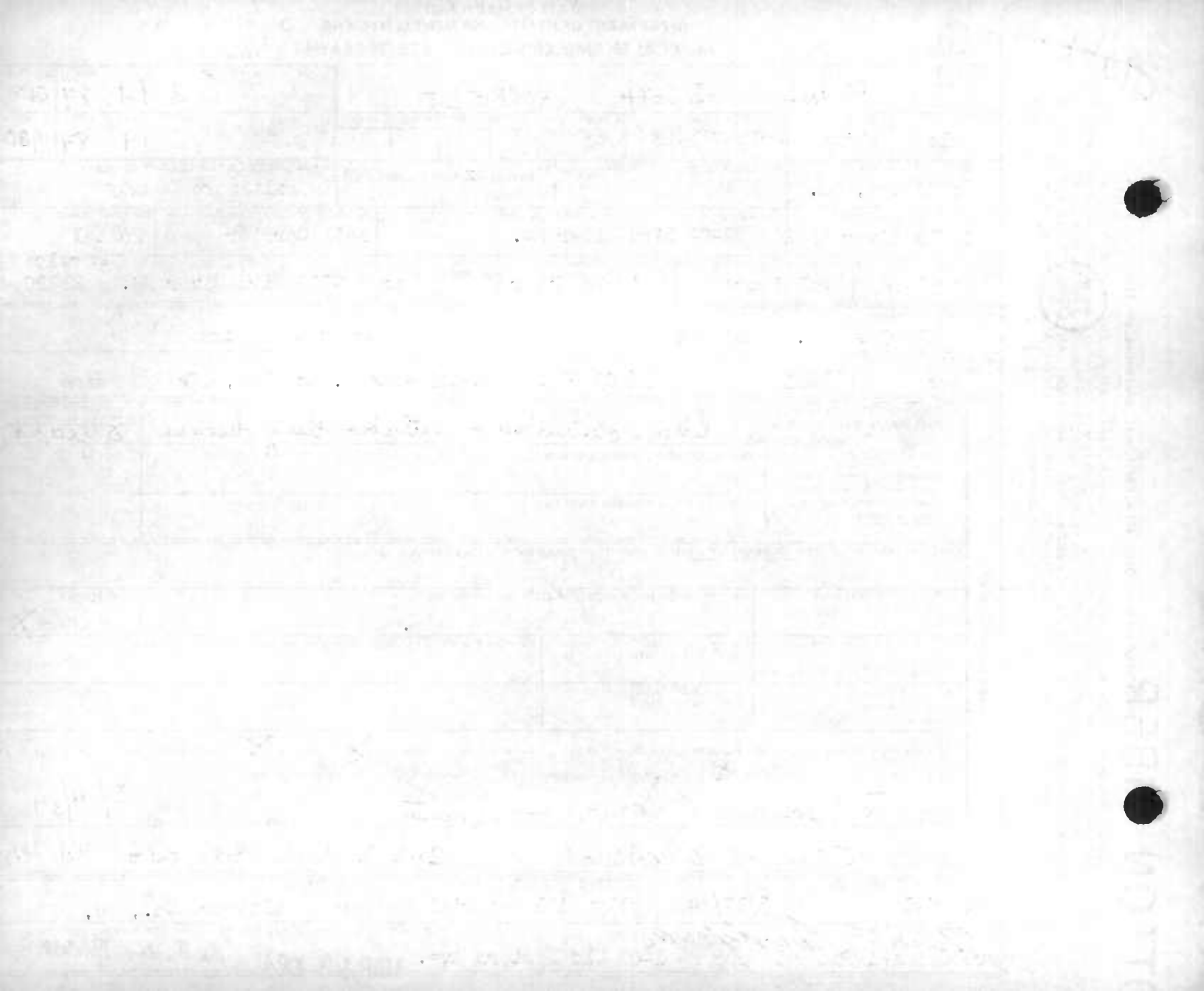
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FRANK JOSEPH ROPPELT						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 14 1984		2b. HOUR 0600			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 7 1918	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 65	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 14 1984		2d. HOUR 1900			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County					
10. CITY OR TOWN OF DEATH Middle River 21220		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9909 Bird River Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Carrier		12b. KIND OF BUSINESS OR INDUSTRY Postal Service			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9909 Bird River Rd. 21220			
14. FATHER'S NAME FIRST MIDDLE LAST Charles G. Roppelt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Burke							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Antoinette F. Roppelt, Wife				17. INFORMANT Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive + restrictive lung disease 4960 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE J. Crossan O'Donovan			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 3/14/84		
EXAMINER'S NAME (TYPE OR PRINT) J. Crossan O'Donovan			ADDRESS 2112 Dundalk Ave., Balto., Md. 21222								
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 3/17/84		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR Prudzenski Funeral Home PA 1407 Old Eastern Ave.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

MAR 19 1984



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 06475									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTOINETTE ROSATI					2a. DATE OF DEATH MONTH DAY YEAR 03 15 '84			2b. HOUR 2:10P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 5, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE 5529 Hillen Road 21239	
FATHER'S NAME FIRST MIDDLE LAST Camille Bianco					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 213-20-8556		17. INFORMANT ADDRESS Anna Eberwein 5529 Hillen Rd. 21239				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2765 SEVERE DEHYDRATION WITH ASSOCIATED ELECTROLYTE IMMEDIATE CAUSE (a) INBALANCE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MARKED CACHEXIA DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/13 , 19 84 , to 3/15 , 19 84 , that (I) (we) lost saw the deceased alive on 3/15 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. Manders, MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3-15-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND A. NZE, M.D.						22e. ADDRESS GBMC - 6701 N. CHARLES STREET 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar 20 1984		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR MAR 19 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) IRWIN, Frederick B		FIRST MIDDLE LAST ROSE		2a. DATE OF DEATH MONTH DAY YEAR March 6, 1984		2b. HOUR 7:12 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 13 09		6. AGE (IN YEARS (LAST BIRTHDAY)) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nancy A. not comp. Remodeling		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Bernard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia K. Spindler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES			
16b. SOCIAL SECURITY NO. 4960		17. INFORMANT Barbara M. McPherson		ADDRESS St. Joseph Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 3/3/84 19 to 3/6/84 19, that (we) last saw the deceased alive on 3/6/84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lester A. Hall Jr. M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/6/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-9-84		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE P. R. Randall			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06477

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Geraldine H. Ross			2a. DATE OF DEATH MONTH DAY YEAR march 23 1984			2b. HOUR 5⁵⁰ AM			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 3 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH 21204 Balto county MD.			
10. CITY OR TOWN OF DEATH Towson Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice Dulaney Valley Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife & Sec - Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Towson Md. 7512 Far Hills Dr. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Eldridge P. Burns				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel WEAL Burns					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-01-6498		17. INFORMANT ADDRESS Charles P. Ross 7512 Far Hills Drive 21204					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1749

IMMEDIATE CAUSE (a) **metastatic Brain Tumor**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

History of Breast and Lung Cancer

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE K. Faulkner MD				DEGREE MD		22c. DATE SIGNED 3-23-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kendall Faulkner MD.				22e. ADDRESS 2300 Dulaney Valley Rd. 21204 Stella Maris Hospice			

23a. BURIAL, CREMATION, REMOVAL Crementation		23b. DATE 3-23-1984		23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
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24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home		ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE R. K. ...	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

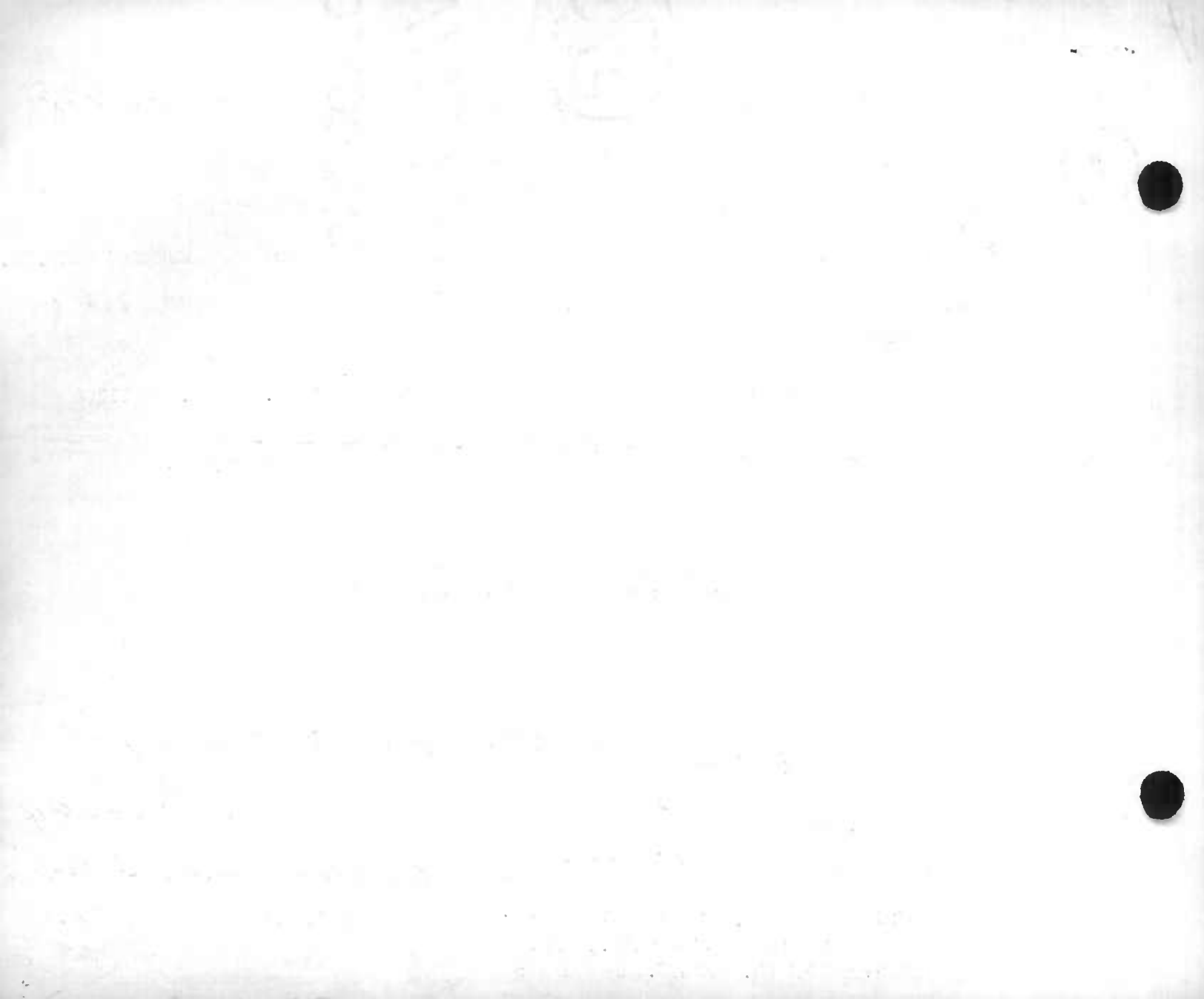
1. DECEASED NAME (TYPE OR PRINT) THEODORE RUDO			2a. DATE OF DEATH MONTH DAY YEAR 3-5-84			2b. HOUR MIN. 8 25					
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 3 26 20		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Collector		12b. KIND OF BUSINESS OR INDUSTRY VENDING MACH. CO.			
13a. STATE MD				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8139 Scotts Level 21208	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT RUDO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH NAIMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WWII=ARMY 220-05-8786		17. INFORMANT MRS. EVA RUDO 8139 SCOTTS LEVEL RD. BALTO., MD 21208					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic pancreatic carcinoma 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Diabetes mellitus											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-25-84 to 3-5-84 that (I) (we) lost saw the deceased alive on 3-5-84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Soonchal Hong			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3-5-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOON CHUL L HONG			22e. ADDRESS Baltimore County General Hosp.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 8, 1984		23c. NAME OF CEMETERY OR CREMATORY AITZ CHAIM			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.						25a. DATE REC'D. BY REGISTRAR MAR 9 1984			25b. REGISTRAR'S SIGNATURE John Davidson-Randall		
6010 REISTERSTOWN RD. BALTO., MD 21215											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				06479			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Phillip L. SACKER				MONTH DAY YEAR 03 20 84			
3. SEX MALE				4. RACE WHITE		5. DATE OF BIRTH	
				1 MONTH 27 DAY 31 ^R		6. AGE (IN YEARS LAST BIRTHDAY)	
				75		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				COUNTY MD.	
10. CITY OR TOWN OF DEATH Ruxton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MAJOR CARE - RUXTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR State of Md. Univ. Hospital	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN	
14. FATHER'S NAME FIRST MIDDLE LAST Claude Sacker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Prucha			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 218-28-0256		17. INFORMANT Genevieve Sacker	
						7411 Kenlea Ave. Balto., Md. 21236	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) CA. OF PROSTATE WITH DUE TO, OR AS A CONSEQUENCE OF METASTASIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Celair E. Parra				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Celair E. Parra, MD PA				22e. ADDRESS 7122 Harford Rd. (444-5656) Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3-23-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				25a. DATE REC'D. BY REGISTRAR MAR 23 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Samuel Salganek			2a. DATE OF DEATH MONTH 3 DAY 10 YEAR 84			2b. HOUR 929 M.					
3. SEX male		4. RACE White/XXXXX		5. DATE OF BIRTH MONTH 9 DAY 2 YEAR 10		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS _____ DAYS _____		8. IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (COUNTRY) RHODE ISLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto Co. MD.					
10. CITY OR TOWN OF DEATH Iowson			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hospice Unit Stella Maris			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLUMBER			12b. KIND OF BUSINESS OR INDUSTRY PLUMBING		
13a. STATE NEW YORK			13b. COUNTY ROCKAWAY PARK			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS APT. 7W(11694)XXXXXX 1 BEACH 105th ST		
14. FATHER'S NAME FIRST JACOB MIDDLE _____ LAST SALGANEK			15. MOTHER'S MAIDEN NAME FIRST GOLDIE MIDDLE _____ LAST NULMAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 102-03-2102			17. INFORMANT MRS. MOLLIE SALGANEK 1 BEACH 105th ST., APT. 7W ROCKAWAY, NEW YORK					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1889

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Metastatic Gastric Carcinoma**(b) Carcinoma of the Bladder**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/27 19 84 to 3/10 19 84 , that (I) (we) lost saw the deceased alive on 2/27 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kendall Faulkner MD				DEGREE MD		22c. DATE SIGNED 3/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kendall Faulkner MD				22e. ADDRESS Stella Maris - Hospice Unit Dix Valley Rd. Iowson Md. 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL-BURIAL		23b. DATE 3/12/84		23c. NAME OF CEMETERY OR CREMATORY NEW MONTEFIORE CEM		23d. LOCATION CITY OR TOWN COUNTY STATE PINELAWN, LONG ISLAND, NEW YORK	
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24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215		25a. DATE REC'D. BY REGISTRAR MAR 14 1984		25b. REGISTRAR'S SIGNATURE Jana Davidson-Kendall	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 06481							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice Blanche Scattergood					2a. DATE OF DEATH MONTH DAY YEAR 3 24 84			2b. HOUR 6 10 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8---27---1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
10. CITY OR TOWN OF DEATH Pikesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pikesville Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1918 Littlestown Pike 2157	
14. FATHER'S NAME FIRST MIDDLE LAST Wellington Lloyd				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Millis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-12-2320		17. INFORMANT ADDRESS 229 Goodwin Quarry Rd. Westminster Md 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Diffuse Metastatic Breast cancer								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/14 19 84 to 3/24 19 84, that (I) (we) saw the deceased alive on 3/22 19 84, and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David B. Bobb MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold B Bobb				22e. ADDRESS 7220 Park Heights 21208					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-27-1984		23c. NAME OF CEMETERY OR CREMATORY Meadow Branch		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.			
24. FUNERAL DIRECTOR Thomas D. Fletcher				25a. DATE REC'D. BY REGISTRAR MAR 28 1984		25b. REGISTRAR'S SIGNATURE John Fowler			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 327-1234.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

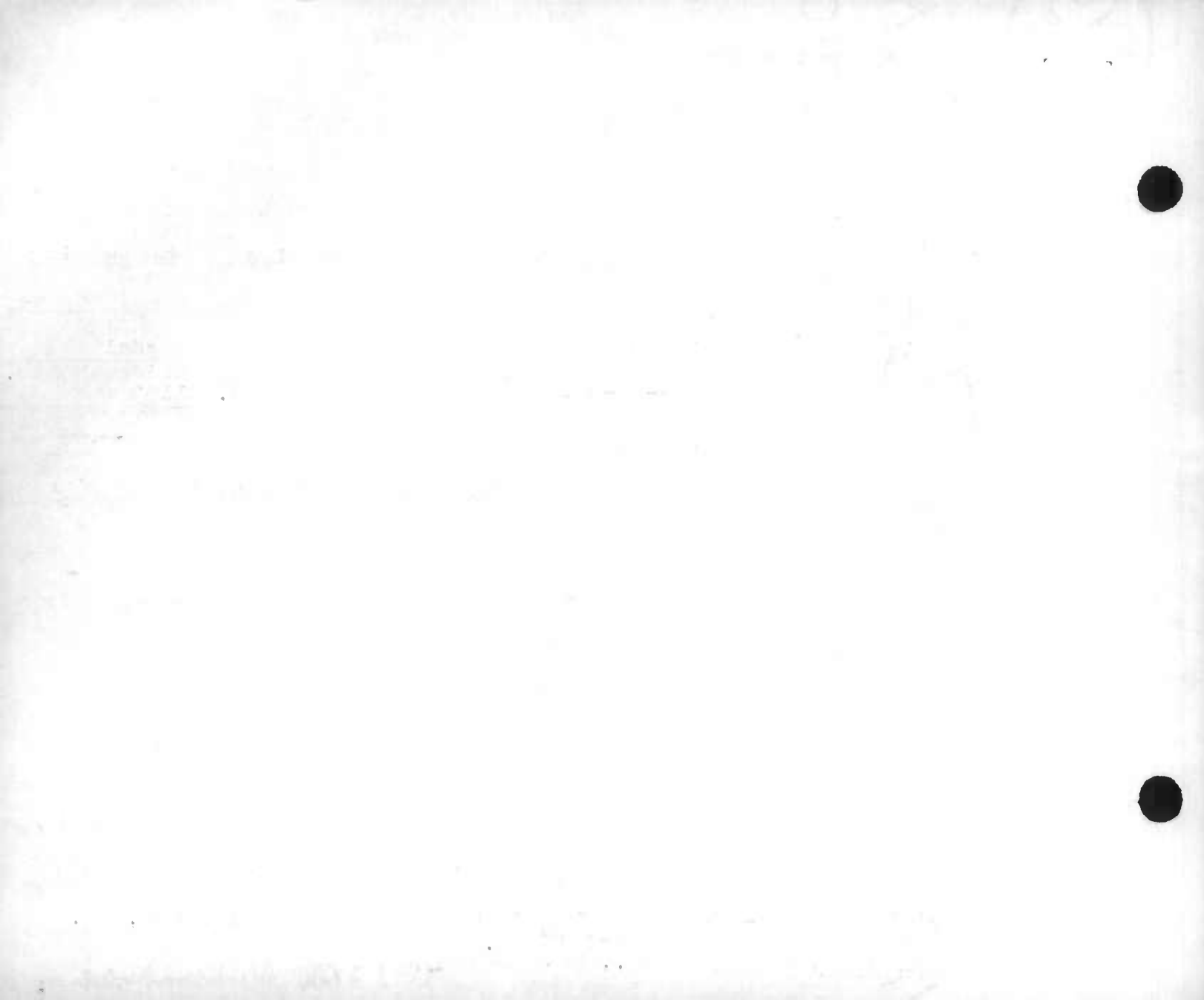
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FOR
STATE
REGISTRAR **Margaret Schafer**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Schafer, Margaret			2a. DATE OF DEATH MONTH DAY YEAR 3 14 84			2b. HOUR 12:50 PM			
3. SEX Female		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 11 29 95		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? US		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
12. CITY OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. General				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		15. KIND OF BUSINESS OR INDUSTRY homemaking	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Miller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Redel			16. STREET ADDRESS / ZIP CODE 9050 Meadow Hgts 21133			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17b. SOCIAL SECURITY NO. 214-44-9288		17. INFORMANT ADDRESS Irene Schafer 9050 Meadow Hgts Rd. 21133				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intractable vent. fibrillation 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 1.5 Hrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/14 19 84 , to 3/14 19 84 , that (I) (we) lost saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Steven G. Steinberg DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 3/14/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN G. STEINBERG						22e. ADDRESS 3502 CROYDON RD Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-17-84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home			24b. ADDRESS 7401 Belair Rd. Balto., Md. 21236			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Julia Davidson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Pauline A. SCHAFER				2a. DATE OF DEATH MONTH DAY YEAR March 15, 1984		2b. HOUR 4:18P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 29, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Riverview Nursing Home				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Ret Secretary	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles S. Schafer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Romoser			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-28-4685		17. INFORMANT ADDRESS Barbara E. Getz 517 Maryland Ave. 21221			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest. Probable Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 15, 1984 , to March 15, 1984 , that we we last saw the deceased alive on March 15, 1984 , and that in my our opinion death occurred on the date and hour and from the causes stated above. we we (did) (did not) view the body after death.							
22b. SIGNATURE HA Quansah				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) QUANSAH				22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 19 1984		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 19 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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1. *Introduction*

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
ANNAMAE M SCHEYER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
03/23/84 | | | |
| 3. SEX
FEMALE | | | | 4. RACE
WHITE | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR
09/23/14 | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. JOSEPH HOSPITAL | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SOLICITOR | | | | 12b. KIND OF BUSINESS OR INDUSTRY
PHONE CO. | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTO. | | | |
| 13c. CITY OR TOWN
BALTO. | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ANDREW BEDNAR | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ELIZABETH ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
210-10-4826 | | | |
| 17. INFORMANT ADDRESS
JACK H. SCHEYER 301 CENTRAL AVE. GLENDON, MD. | | | | 21071 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL
4100 DUE TO, OR AS A CONSEQUENCE OF INFARCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF CORONARY ARTERY DISEASE
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
OLD INFARCTION MYOCARDIAL INFARCTION | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (b) (we) last saw the deceased _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] MD | | | | 22c. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22d. DATE SIGNED
3/23/84 | | | | 22e. ADDRESS | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 23b. DATE
MAR. 26, 1984 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
GREEN MOUNT CEM. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR NAME
MITCHELL-WIEDEFELD HOME | | | | 25a. DATE REC'D BY REGISTRAR
MAR 27 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | 25c. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Figure 5

1995

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06485

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY A LAST Schluter | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 14 84 | | 2b. HOUR
245P
M |
| 3. SEX
FEMALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8-13-1897 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
86
YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO. MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MANOR CARE NURSING Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. STATE
MD. | | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES RUZICKI | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA MILLER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
- | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-03-2835 | 17. INFORMANT
ADDRESS
HENRY SCHLUTER
121 SECOND ST.
NOKOMIS, FLA. 33555 | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) - Acute Myocardial infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) - Arteriosclerotic cardiovascular disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) - | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
30 minutes |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/07/81 to 3/14/84, that (he) (she) (it) (we) (they) saw the deceased alive on 3/14/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
K. M. TUN. | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
3/14/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
K. M. TUN. | | 22e. ADDRESS
Manor Care Rossville. | |

| | | | |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
3-16-84 | 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD CEM. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. |
| 24. FUNERAL DIRECTOR
NAME
Lillian FH | | 25a. DATE REC'D. BY REGISTRAR
MAR 19 1984 | |
| ADDRESS
7401 Belair Rd | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12/55/

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

06486

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---------------------------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
CORNELIUS AMBROSE SCHMIDT | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 24, 1984 | | 2b. HOUR
12:44 P M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 5, 1908 | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Valley Nursing & Convalescent Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Joseph Schmidt | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie Elizabeth Kelly | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-09-7340A | 17. INFORMANT
Margaret M. Schmidt North, 21212 | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cerebrovascular Disease
4370
DUE TO, OR AS A CONSEQUENCE OF
(b) Peripheral Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/81 , 19 84 , to 3-24 , 19 84 , that (I) (we) saw the deceased alive on 3-19 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Marion C. Kowalewski | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
3-26-84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Marion C. Kowalewski, M.D. | | 22e. ADDRESS
8604 Harford Rd. Baltimore, Md. | |

| | | | |
|--|------------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
March 26, 1984 | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Md. |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1984 | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, immediate notification must be notified.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. 06487 | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) MARY E. Schneeberger | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 3-5-84 | | | 2b. HOUR
11:20 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR JAN. 31 1881 | | 6. AGE (IN YEARS LAST BIRTHDAY)
103 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE County MD. | | | |
| 10. CITY OR TOWN OF DEATH
RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHAPEL HILL CONV. HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CASHIER | | 12b. KIND OF BUSINESS OR INDUSTRY
THEATER | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
BALTIMORE | | 13e. STREET ADDRESS
4229 HICKORY AVENUE, 21211 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN GRIMM | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216-28-0666 | | 17. INFORMANT
ADDRESS SEVERNA PARK, MD.
706 DILL ROAD, 21146 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest 20
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) to ASUD CHF and (c) sub-rotical
DUE TO, OR AS A CONSEQUENCE OF
(c) Infarction.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
SENILITY. OLD AGE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-1-83 to 3-5-1984 , that (I) (we) lost saw the deceased alive on 3-5-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R-M. Shah | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
3/8/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R-M-SHAH. | | | | | 22e. ADDRESS
5316 OLD COM RD.
RANDALLSTOWN MD 21133 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
03-09-84 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HUBBARD FUNERAL HOME, INC. 4107 WILKINS AVE. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 9 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | |

SECRET



SECRET

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
George Schriner | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 13 84 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 8 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
Dundalk | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1913 Jasmine Road | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Receiver | | 12b. KIND OF BUSINESS OR INDUSTRY
Food Fair | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
1913 Jasmine Road 21222 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
George E. Schriner | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Miller | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
218-03-8202 | | 17. INFORMANT
Bernard Mayo | | ADDRESS
Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Undifferentiated Carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Dr. David L. Siegel | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/14/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. David L. Siegel | | 22e. ADDRESS
Baltimore Hosp. 4940 Eastern Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/16/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc. | | ADDRESS
7922 Wise Avenue Dundalk, MD. 21222 | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06489

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|---|---------------------------------------|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
<i>Marion Schroeder</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>March 25 1984</i> | | | 2b. HOUR
<i>12 P M</i> | | | | |
| 3. SEX
<i>male</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>4 27 12</i> | | 6. AGE (IN YEARS (LAST BIRTHDAY))
<i>71</i> | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
<i>YRS.</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore County</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Armcast Nursing Home</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Truck Driver</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Md.</i> | | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>812 Regester Ave. 21239</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Louis Winfield Schroeder</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Hattie D. Price</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | | | |
| 16b. SOCIAL SECURITY NO.
<i>214-14-3212A</i> | | | 17. INFORMANT
<i>Mr. Earle Whitaker</i> | | | ADDRESS
<i>8 Edgemoor Road Timonium, Md.</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Generalized Aortic</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Sudden</i>
5+ yrs | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN CAUSE I AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>no</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (i) this hospital attended the deceased from <i>7 February 1984</i> to <i>25 March 84</i> , that (ii) <i>last</i> saw the deceased alive on <i>16 March 84</i> , and that in my opinion death occurred on the date and hour and from the causes stated above, (iii) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Monte D. ...</i>
22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22c. ADDRESS | | 22d. DATE SIGNED
<i>3/25/84</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Removal</i> | | | 23b. DATE
<i>3/25/84</i> | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Anatomy Board</i> | | | | | | ADDRESS
<i>Balto., Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 28 1984</i> | | |
| 25b. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | | | | | | | | |



March 1st 1898
Dear Sir,
I have the honor to acknowledge
the receipt of your letter of the
1st inst. in relation to the
above matter.

Very respectfully,
J. H. [Signature]

Yours truly,
J. H. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Muriel Lola Schroeder | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 21, 1984 | | 2b. HOUR
1:00 PM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 16, 1918 | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3010 Virginia Ave., 21227 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Inspector | | 12b. KIND OF BUSINESS OR INDUSTRY
Misty Harbor | |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
3010 Virginia Ave., 21227 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Duncan Graham | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Charlotte Mattes | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-14-1932 | | 17. INFORMANT
ADDRESS
Glenn E. Graham Toddsville, Md. 21672
Box 270 Bishops Head Rd., | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Vant F... AS...
(c) 125 12 | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
341 57 | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 57, to 19 57, that (I) (we) last saw the deceased alive on 19 57, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true, did not view the body after death.) | | | | | | |
| 22b. SIGNATURE
Dr. Raymond D. Bahr, MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/25/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Raymond D. Bahr, MD | | 22e. ADDRESS
Wilkins and Pine Heights Aves., Baltimore | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/24/1984 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge, Howard Co., Md. | | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Homes | | BALTIMORE, MD., 21225
237 E. Patapsco Ave., | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1984 | | |
| | | 25b. REGISTRAR'S SIGNATURE
a. m. Wilson-Randall | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order to have an autopsy.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06491

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|---|-------|
| 1. DECEASED NAME
(TYPE OR PRINT)
BESSIE SCHUCHALTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-8-84 | | | 2b. HOUR
5:20
M | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 22, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
7 HRS. MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BALTIMORE COUNTY GEN. HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
OWINGS MILLS | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
16 GREEN MOUNTAIN CT. 21117 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ABRAHAM DROBIS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BELLA UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-42-5607 | | 17. INFORMANT
ADDRESS
STUART SCHUCHALTER
3805 NEMO RD., RANDALLSTOWN, MD 21133 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
5120
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
DIABETIS MELLITUS | | | | | | | | | | |
| 19a. DATE OF OPERATION
3-8-84 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
LEFT CHEST TUBE - 20 PNEUMOTHORAX | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | CITY OR TOWN | | STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-7 , 19 84 , to 3-8 , 19 84 , that (I) (we) lost saw the deceased alive on 3-8 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3-8-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ORLANDO B. CONNOR MD. | | | 22e. ADDRESS
BEGH - RANDALLSTOWN MD. 21133 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
MAR. 9, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
SHOMREI HADATH VE TZEMECH SEDEK | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE BALTO MD | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR'S SIGNATURE
MAR 14 1984
[Signature] | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. DECEASED NAME | | | | 20. DATE OF DEATH | | | | 2b. HOUR | | | | | |
|---|--|--|--|--|--|--------------------------------------|--|--|--|--|--|--|--|
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | | IF UNDER 1 YEAR IF UNDER 24 HRS. | | | | | |
| Charles Arthur Scott | | | | March 22, 1984 | | | | 5:30 P M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Male | | White | | August 17 1922 | | 61 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Penna. | | U.S.A. | | | | Baltimore County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Parkville | | 2906 Kings Ridge Rd. (Residence) | | | | | | Ret. Construction Engineer | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | |
| Maryland | | | | Baltimore | | Parkville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 21234 2906 Kings Ridge Rd. Apt C | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | |
| Raymond Scott | | | | Cora Martin | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | | |
| No YES WWII | | | | 183-18-7091 | | Mrs Violet G Scott | | | | Same As 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory failure</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of the colon with</u> | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>liver metastases</u> | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Liver failure</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-22-84</u> 19 <u>84</u> , to <u>3-4</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3-4</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| <u>m2 Didolkar</u> | | | | M.D. | | | | 3-22-84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| Dr. Mukund Didolkar M.D. | | | | University Hospital Baltimore, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 3/24/84 | | Oak Lawn Cemetery | | | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | | MAR 23 1984 | | <u>Mar Davidson-Randall</u> | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 6 4 9 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Harry - Selway | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 12, 1984 | | | 2b. HOUR
6 P. M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 11 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | |
| 12. CITY OR TOWN OF DEATH
Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Long Green Nursing Home | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Foreman | | 15. KIND OF BUSINESS OR INDUSTRY
Marietta | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3118 Mareco Ave. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James - Selway | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Fisher | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
yes WW I | | | 16b. SOCIAL SECURITY NO.
212-03-3895 | | | 17. INFORMANT ADDRESS
Genevieve Selway (wife) same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCVD
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Fr left hip - malnutrition | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
28 | |
| | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR AM. MONTH DAY YEAR
2:30 P.M. 2-10-84 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)
Subject fell. | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
street | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3100 blk. Mareco Ave. Balto. Md. | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on 3/6 19 84
above, (I) (we) (did not) view the body after death. | | | | | | | | 22b. SIGNATURE
R. Freeman | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Norman Freeman | | | | | | | | 22d. ADDRESS
11 W. 29th St. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/16/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. Nat'l | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto. 21213 | | | | | | 25a. DATE REC'D BY REGISTRAR
MAR 16 1984 | | 25b. REGISTRAR'S SIGNATURE
Jane Davidson-Hendall | |

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ASCD

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For left trip - 10/1/10

10/1/10

10/1/10

10/1/10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06494

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
REGINA SELZER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 3, 1984 | | 2b. HOUR
8:35 A.M. | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 8, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
94 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SWITZERLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
PIKESVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PIKESVILLE NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
3513 LEE CT. #21208 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
ABRAHAM FABRICANT | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA UNKNOWN | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 16b. SOCIAL SECURITY NO.
215-48-4900 | | 17. INFORMANT
SAMUEL SELZER | | 17b. ADDRESS
2312 MELINDA DR. OWINGS MILLS, MD 21117 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
4860
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Arteriosclerotic Cardiovascular Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 2 19 84 , to 3/3 19 84 , that (ii) (we) last saw the deceased alive on 2 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Dr. Ronald Friedman | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. Ronald Friedman MD | | 22e. ADDRESS
6715 Park Hts Ave. 2121 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
MAR 4, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
HEBREW YOUNG MEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC. | | ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR
MAR 9 1984 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," it shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06495

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Alma H Sewell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-24-84 | | | 2b. HOUR
10³⁰ AM | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 23 00 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
Balt. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto Co. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Joseph Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
812 Register Ave 21239 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert T. Lemkuhl | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Muthert | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-38-8565 D | | 17. INFORMANT
ADDRESS
Medical Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Pulmonary Thrombosis
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) Arterio Sclerotic Cerebrovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Heart Failure + Arterio Sclerotic | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-18-84 , 19 84 , to 3-24-84 , 19 84 , that (I) (we) last saw the deceased alive on 3-24-84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Benjamin J. Mc... | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/24/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Mar. 28, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Pk. Parkville, Balto. Co., Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

BP

NUMBER

NOV 1944

271

20%

1944

1944

1944

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06496

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FRANCES (nmi) Shiner | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/29/84 3 29 84 | | | 2b. HOUR
11 44a | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 29 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
Towson Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Joseph Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home maker | |
| 13a. STATE
Md | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Safranek | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Rach | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. IF YES, GIVE WAR OR DATES | | 17. ADDRESS
2120 York Rd. 21204 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4140 CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC HEART DISEASE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 DAYS
2 DAYS
YEARS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 3-27 19 84 , to 3-29 19 84 , that (we) lost saw the deceased alive on 3-29 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
George C. Secada-Lovio, MD | | | | | | 22c. DATE SIGNED
3-29-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE C. SECADA-LOVIO, M.D. | | | | 22e. ADDRESS
ST JOSEPH HOSPITAL
7620 YORK ROAD. TOWSON, MD. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
3/30/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Walter Brooks Bradley, Inc. Dundalk, MD 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1984 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. NAME _____
2. ADDRESS _____
3. CITY _____
4. STATE _____
5. ZIP _____
6. DATE _____

7. REASON FOR REQUEST _____
8. DATE OF REQUEST _____
9. DATE OF RECEIPT _____
10. DATE OF PAYMENT _____
11. DATE OF CLOSURE _____
12. DATE OF REVIEW _____

13. DATE OF APPROVAL _____
14. DATE OF DENIAL _____
15. DATE OF REJECTION _____
16. DATE OF REFUSAL _____
17. DATE OF CANCELLATION _____
18. DATE OF EXPIRATION _____

CERTIFICATE OF DEATH

06497

1. FOR
STATE
REGISTRAR

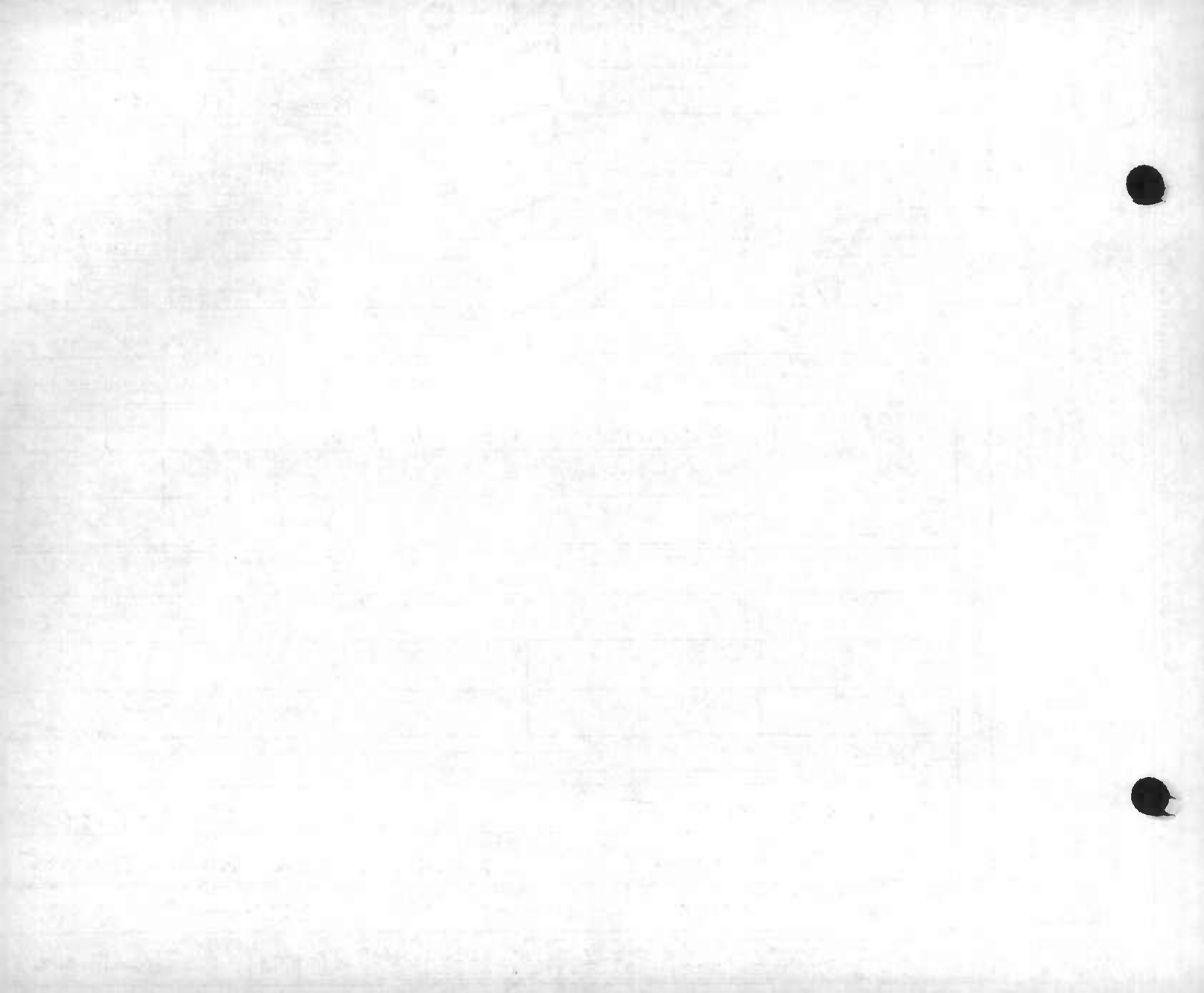
REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
GEORGE JOSEPH SHINER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 17 1984 | | 2b. HOUR
1:40 |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 13 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
RIVERVIEW NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY
DAVIS & SON |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. CITY OR TOWN
BALTIMORE | 13c. STREET ADDRESS
21213 3907 CHESTERFIELD AVE. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE SHINER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AGNES unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-01-7894 | | 17. INFORMANT
ADDRESS
Catherine Shiner (wife) same address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma - lung
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Michael Schwartz MD</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/17/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael Schwartz MD | | 22e. ADDRESS
606 HAMMONDS LANE Baltimore, Md. 21225 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
3/20/84 | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
SCHIMUNEK FUNERAL HOME, INC.
3331 Brehms Lane, Balto. Md. 21213 | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1984 | 25b. REGISTRAR'S SIGNATURE
<i>Lelia Davidson-Randall</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

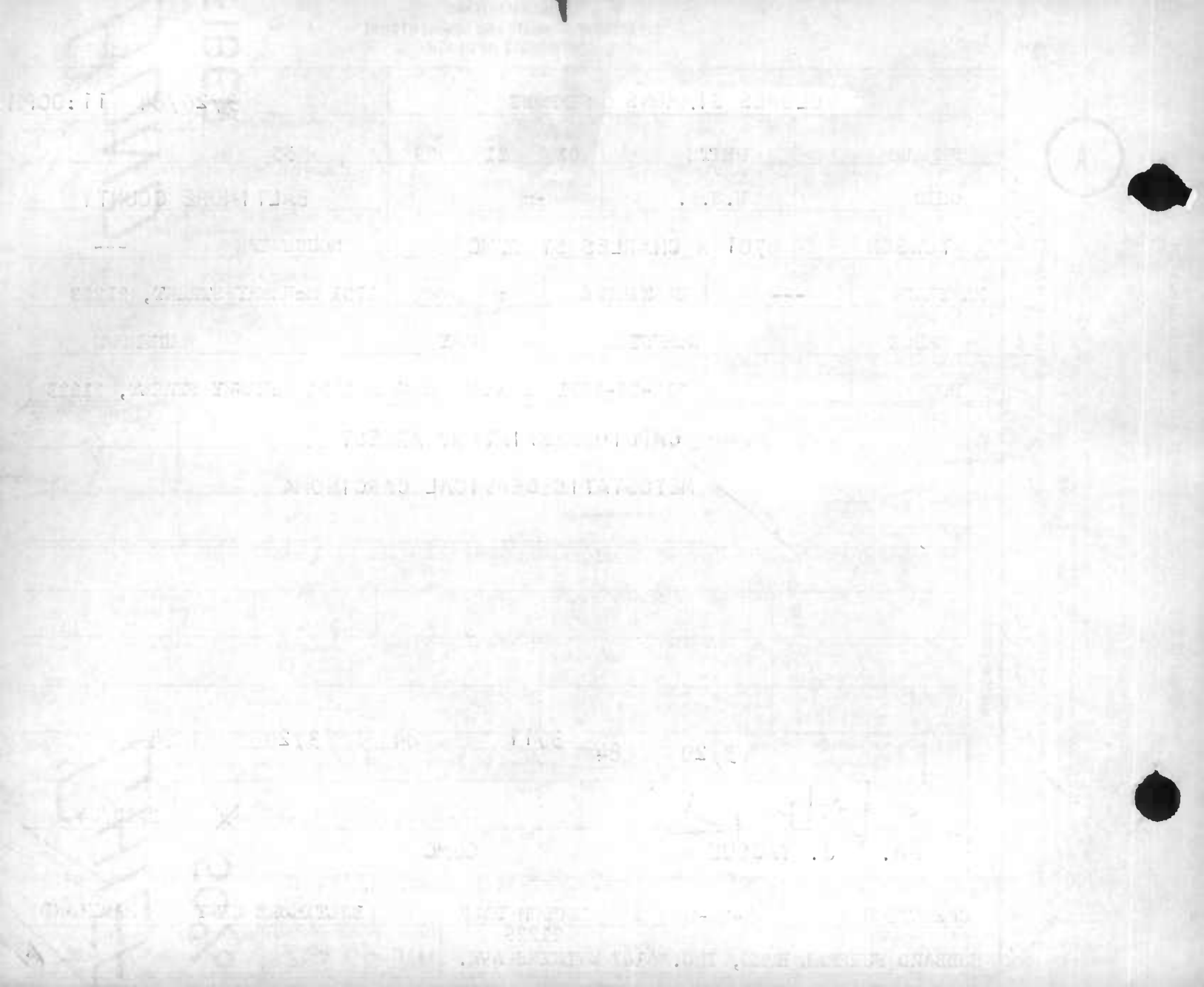


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copy part. Page 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a coroner's inquest may be required.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | |
|---|--|--|------------------------------|---|--|--|---|--|--|---|--------------------------------|----------|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST MIDDLE LAST | | | | | 3/20/84 | | | 11:00PM | | |
| DOLORES I. SIMMONS | | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| FEMALE | | | WHITE | | 01 21 29 | | | 55 YRS. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| OHIO | | | U.S.A. | | | | | BALTIMORE COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| TOWSON | | | | | 6701 N CHARLES ST GBMC | | | | | HOUSEWIFE | | | --- | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| MARYLAND | | | | | --- | | BALTIMORE | | | | 1731 McHENRY STREET, 21223 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | |
| BRUCE SCHUSTER | | | | | MARY UNKNOWN | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | |
| NO | | | | | 272-26-1571 | | SHERMAN HARPER 1731 McHENRY STREET, 21223 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> | | | | | | | | | | | | | | | |
| 1809 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: | | | | | | | | | | | | | | | |
| (b) <u>METASTATIC CERVICAL CARCINOMA</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/20 84 3/11 19 84 3/20 19 84, that (I) (we) last saw the deceased alive on 3/20 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | | | | | |
| DR. J. YACOB | | | | | | | | | 3/20/84 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | | | |
| | | | | | | GBMC | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | |
| CREMATION | | | | 03-24-84 | | LOUDON PARK | | | BALTIMORE CITY MARYLAND | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | | | MAR 23 1984 | | | [Signature] | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
NORMAN WALTER SINGER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 6 84 | | | 2b. HOUR
6-35A M. | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 1, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BALTIMORE COUNTY GEN. HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY
FURNITURE CO. | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
RANDALLSTOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ABRAHAM SINGER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IDA SINGER | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) YES WWII-ARMY | | | |
| 16a. SOCIAL SECURITY NO.
213-14-0403 | | | 17. INFORMANT MRS. BEATRICE SINGER
8709 MEADOW HTS. RD. RANDALLSTOWN, MD 21133 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-pulmonary arrest 20 to 4100
DUE TO, OR AS A CONSEQUENCE OF
(b): acute myocardial infarction with
DUE TO, OR AS A CONSEQUENCE OF
(c): sustained VT-VF.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCD. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-6-84 to 3-6-84 , that (I) (we) last saw the deceased alive on 3-6-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R.M. Shah MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-6-84. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R.M. SHAH, M.D. | | | | | | 22e. ADDRESS
BAL. COUNTY General Hospital
Randallstown, MD. 21133. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
MAR. 7, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
SHAAREI ZION CEM. | | 23d. LOCATION
ROSEDALE BALTO. MD | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25. DATE REC'D. BY REGISTRAR
MAR 9 1984 | | 25. REGISTRAR'S SIGNATURE
<i>Julia Davidson</i> | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

1

CHIEF

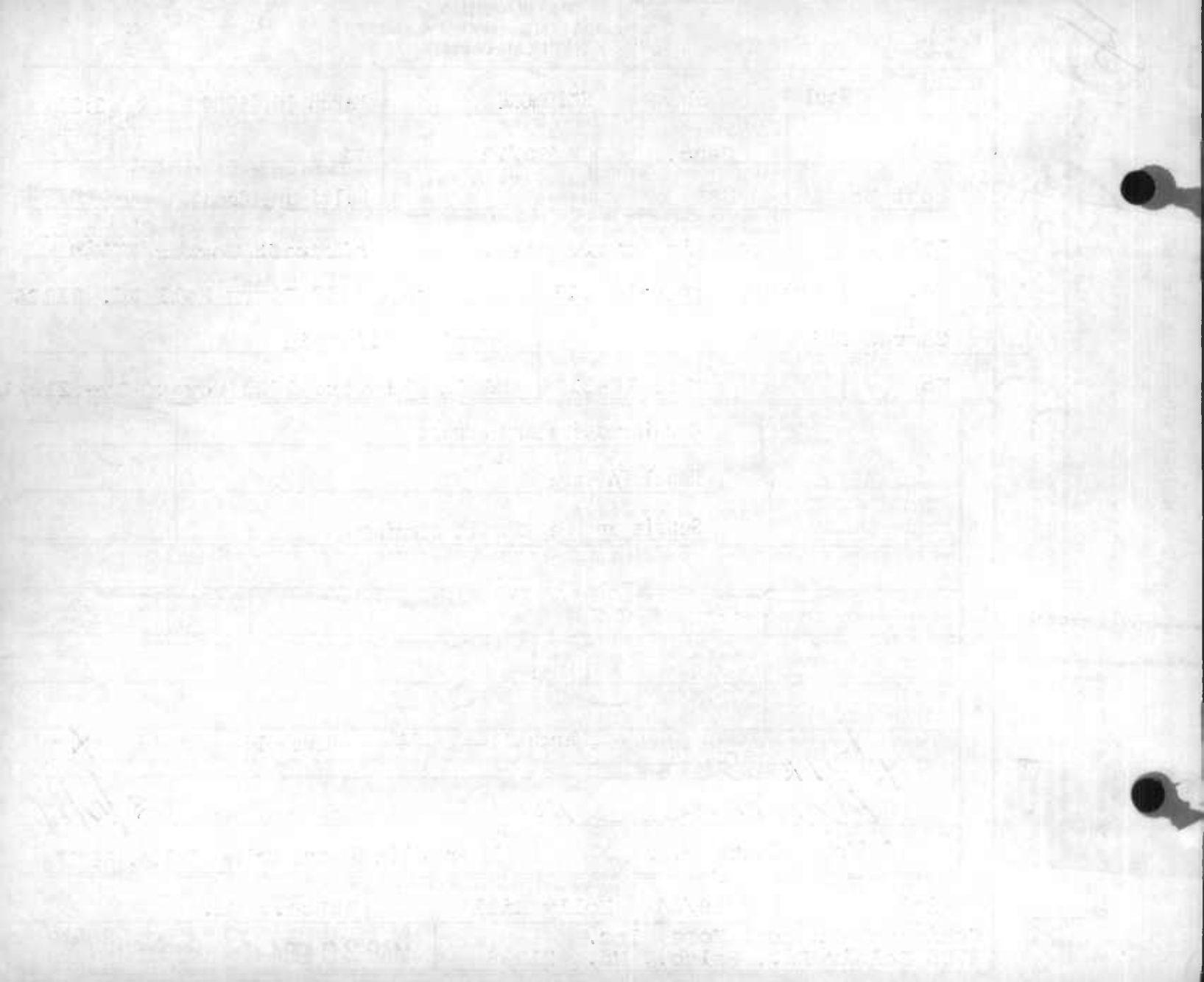
COLL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "X", item 18 must be completed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 06500 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Paul Elwyn SKIDMORE | | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 16, 1984 | | | |
| 3. SEX
Male | | | | 2b. HOUR
3:25p M | | | |
| 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
4/20/12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Square Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Aircraft Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Martin | |
| 13a. STATE
Md. | | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Perry Hall | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Skidmore | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Gillespie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]
No - | | 16b. SOCIAL SECURITY NO.
234-18-3184 | | 17. INFORMANT ADDRESS
Edwin Skidmore, 1623 Howard Ave. 21221 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
0389
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Renal failure
(c) Sepsis and metastatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 2, 1984, to March 16, 1984, (that I/we) lost saw the deceased alive on March 16, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Jeffrey Wallace, M.D. | | 22c. DATE SIGNED
3/14/84 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey Wallace, M.D. | |
| 22e. ADDRESS
9000 Franklin Square Drive Balto. 21237 | | 22f. DATE REC'D. BY REGISTRAR
MAR 20 1984 | | | | 22g. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
3/19/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | |
| 24. FUNERAL HOME, INC.
Schunke Funeral Home, Inc.
9705 Belair Rd., Balto., Md. 21236 | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO.
06501 | |
|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT F. SKUTCH, JR. | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 25, 1984 | | 2b. HOUR
9:10P. ^M |
| 3 SEX
MALE | 4 RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
AUGUST 15, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74
YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY ^{MD.} | | |
| 10. CITY OR TOWN OF DEATH
PIKESVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PIKESVILLE NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ATTORNEY | 12b. KIND OF BUSINESS OR INDUSTRY
AT LAW | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT F. SKUTCH | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
RACHEL FRANK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE NUMBER)
WWII-GUARD 216-10-8307 | | 17. INFORMANT
ADDRESS
MRS. EVELYN SKUTCH 16 FENCEPOST CT. 21208 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>
<u>4140</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 WEEK.</u>
<u>5 YEARS.</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>PARKINSONISM.</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. certify that (I) (this hospital) attended the deceased from <u>6-30</u> , 19 <u>70</u> , to <u>3-25</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2-1-</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Barnett Berman, M.D.</u>
DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-26-84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. BARNETT BERMAN | | | | 22e. ADDRESS
611 PARK AVE. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
3/27/84 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW MEMORIAL PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 28 1984 | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Lia Davidson-Rendell</u> | | | | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06502

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Joseph John Sladek | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 17, 1984 | | 2b. HOUR
10:30^P | | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 4 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 8. IF UNDER 24 HRS.
HOURS MIN.
00 00 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7820 Old Harford Rd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Distribution | | 12b. KIND OF BUSINESS OR INDUSTRY
Gas & Elec. | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7820 Old Harford Rd. 21234 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph E. Sladek | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Kolarik | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | 16b. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT ADDRESS
Eleanora Sladek (wife) same address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Colon Carcinoma
1539
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/14, 1983 , to 3/17, 1984 , that (I) (we) lost saw the deceased alive on 3/17, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Davis JH | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE, SIGNED
3/19/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Davis Hahn | | | 22e. ADDRESS
Good Samaritan Professional Bldg. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/21/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
9705 Belair Rd., Balto. Md. 21236 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1984 | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Rodwell | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

7

✓

FIBER

DOWN

100% DOWN

CHIEF

20%

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

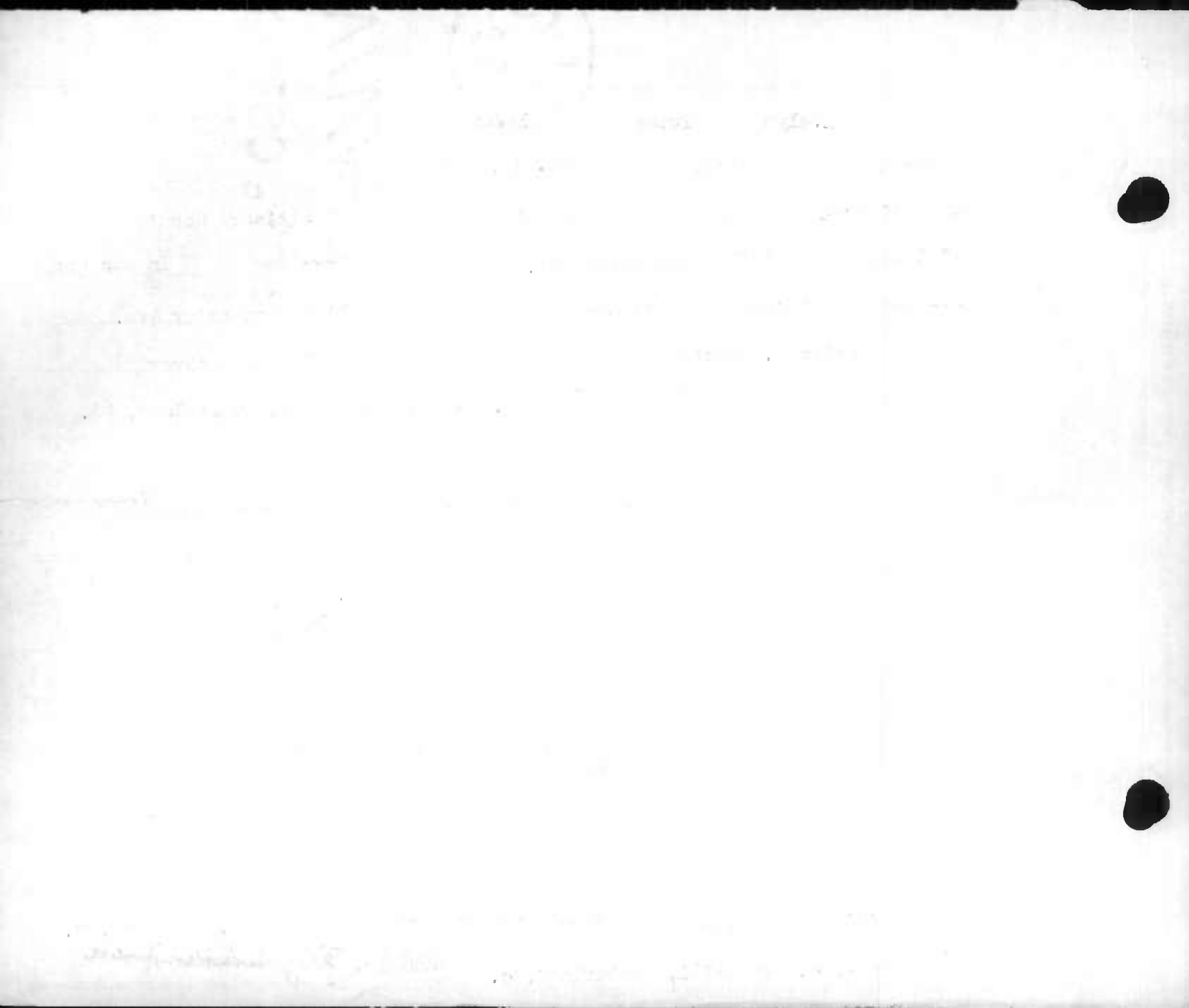
06503

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Evelyn Irene Sleeman | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 6 84 | | 2b. HOUR
M
AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 12, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1132 Dorchester Ave. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
In Own Home |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles S. Kesner | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Louise Rodeheaver | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-05-5483 | | 17. INFORMANT
ADDRESS
Mr. Eugene Ray Kesner, Cumberland, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aut MI
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) ASHD Plus D. Mellitus
DUE TO, OR AS A CONSEQUENCE OF
(c) Years | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/28/1982 to 3/6/1984 , that (I) (we) last saw the deceased alive on 2/9/1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/7/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Adnan M. Sonmez | | 22e. ADDRESS
500 N. Rolling Rd. Md. 21228 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-10-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | |
| | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR
NAME
James F. Scarpelli | | ADDRESS
Cumberland, Md. | | 25. DATE REC'D BY REGISTRAR
MAR 14 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06304

1- FOR
STATE
REGISTRAR

REG. NO.


| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ernest N. SMELSER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 12, 1984 | | | 2b. HOUR
11:30p M | | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
6/11/46 | | 6. AGE (IN YEARS LAST BIRTHDAY)
37 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
M.D. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
ROSSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANKLIN SQ. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNK | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
M.D. | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
MIDDLE RIVER | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4 SEAFRIGE RD 21220 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ERNEST SMELSER JR | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSALEE PHILLIPS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
VIETNAM 218423475 | | 17. INFORMANT
ROSALEE SMELSER | | | ADDRESS
ABOVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
5722
DUE TO, OR AS A CONSEQUENCE OF
(b) Hepatic Encephalopathy due to End Stage Liver Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (he (this hospital) attended the deceased from February 24 , 19 84 , to March 12 , 19 84 , that (he (we) lost saw the deceased alive on March 12 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he (we) did not witness the body after death). | | | | | | | | | | |
| 22b. SIGNATURE
Leslie Mukau, M.D. | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
03/12/84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS
9000 Franklin Sq. Dr., 21237 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
3/4/84 | | 23c. NAME OF CEMETERY OR CREMATORY
SECURITY PROCESS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. M.D. | | | |
| 24. FUNERAL DIRECTOR
NAME
J.G. CONNELLY | | | ADDRESS
300 MACE | | | 25a. DATE REC'D. BY REGISTRAR
MAR 14 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>John Andrew Randall</i> | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with vital records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examination may be required at the scene of death.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 06505 | |
|--|--|--|--|---|--|--|--|--|--|-------|--|
| 1. FOR
STATE
REGISTRAR | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
HARRY SMULSON | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 28, 1984 | | | | 2b. HOUR
6:50 AM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT. 12, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JEWISH CONVALESCENT CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6021 BERKELEY AVE. 21209 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAMUEL SMULSON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE PRUCE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-09-9454 | | 17. INFORMANT
MRS. BEVERLY RASHBAUM
6021 BERKELEY AVE. BALTO., MD 21209 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
4860
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 Hrs. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Chronic Brain Syndrome, Arteriosclerotic Heart Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 75 to 3-28 19 84 , that (I) (we) lost saw the deceased alive on 3-27 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Lawrence Solomon MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
March 28, 1984 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lawrence Solomon, M.D. | | | | 22e. ADDRESS
600 Reisterstown Road BALTO., MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAR. 30, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH YEHUDA ANSHE KURLAND | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Sol Levinson & Bros. Inc. | | | | ADDRESS
6010 Reisterstown Rd. | | 25a. DATE REC'D. BY REGISTRAR
APR 2 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

BP _____



FILE



FILE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--------------|---|---|---|------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
Catherine L. SNEAD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 10, 1984 | | 2b. HOUR
8:25A
M |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
11-22-1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANKLIN SQUARE HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANKLIN SQUARE HOSPITAL | | 12b. KIND OF BUSINESS OR INDUSTRY
STORE | |
| 13a. STATE
MD | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM DEMPSEY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY KANE | | 16. STREET ADDRESS / ZIP CODE
3016 PINWOOD AVE. 21214 | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 17b. SOCIAL SECURITY NO.
579-05-2127 | | 18. INFORMANT
ADDRESS
Mrs. William M. Sneed - 3016 Pinewood Ave. 21214 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

4292

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CONGESTIVE HEART FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(c) ASCVD, SEVEREAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Kate Tully</u>
MD | | | | DEGREE
MD | | 22c. DATE SIGNED
3/10/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kate Tully, M.D. | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3-13-84 | | 23c. NAME OF CEMETERY OR CREMATORY
MORELAND MEMORIAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD | |
| 24. FUNERAL DIRECTOR
NAME
Garth Miller - 7527 Harford Rd. | | | | 25. DATE REC'D BY REGISTRAR
MAR 12 1984 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FILED

RECEIVED



DATE: 11-25-1983
TIME: 1:21 PM
BY: [illegible]
TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
RE: [illegible]

CHIEF OF BUREAU
[illegible]
[illegible]
[illegible]

11-25-1983
[illegible]
[illegible]
[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 20 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06307

| | | | |
|--|--|---|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST
EDWARD H. SNYDER | | MONTH DAY YEAR HOUR
3 08 84 11:30^M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| MALE | WHITE | MONTH DAY YEAR
MAY 22, 1915 | 68 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| MARYLAND | USA | | BALTIMORE COUNTY MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| TOWSON | GBMC-6701 N. CHARLES ST. | ENGINEER | U.S. ARMY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? |
| 13a. STATE COUNTY
MD. | | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 13d. STREET ADDRESS | |
| FIRST MIDDLE LAST
JOHN F. SNYDER | FIRST MIDDLE LAST
MARY HAMILTON | 4114 MARY AVE. 21206 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| NO | 215-03-5524 | LENORE C. SNYDER 4114 MARY AVE. 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
1850 IMMEDIATE CAUSE (a) CARDIOPULMONARY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC PROSTATIC CA
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/04 84 to 3/08 84 that (I) (we) lost now the deceased alive on 3/08 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Michael D. Joyce</i> | | DEGREE
M.D. | 22c. DATE SIGNED
3/08/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL JOYCE, M.D. | | 22e. ADDRESS
GBMC-6701 N. CHARLES ST. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| CREMATION | MARCH 10, 1984 | GREEN MOUNT CEM. | BALTIMORE MD. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212 | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1984 | |

John Davidson

3 08 84 11:30P

SHYDER

EDW RD

MALE

BALTIMORE COUNTY

6701 N. CHARLES ST.

TOWSON

ALLIANCE

ALLIANCE

CARDIOPULMONARY FAILURE

METASTATIC PROSTATIC CA

X

48

80\3

48

3\04

3\08

3\08\84

6701 N. CHARLES ST.

MICHAEL JOYCE, M.D.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 WITH VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 6508 | |
|--|-------------------------|--|---|---|-------------------------------|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HARVIENE MYERS SOINE' | | | | | | | | | | 2a. DATE KNOWN
OF DEATH ESTI-
MATED March 8 1984 | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 8, 1913 | 6. AGE (IN YEARS
LAST BIRTHDAY)
70 YRS | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE
PRONOUNCED
DEAD March 8 1984 | | 7c. HOUR
DAY YEAR | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Joseph's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Retired, Vice-Prin. Balto. Co. Sch. | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
527 Park Ave. - 21204 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Carl A.T. Soine' | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
A. Harviene Myers | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
219-18-4104 | | 17. INFORMANT
ADDRESS
Westminster, Md.
Carl W. Soine, 4937 Old Hanover Rd. 21157 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 8880 Acute Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Sudden
(b) Bilateral Hip Fractures - Pinned
DUE TO OR AS A CONSEQUENCE OF Days
(c) Generalized ASCVD
DUE TO OR AS A CONSEQUENCE OF Days
5+ yrs | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Diabetes Mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/5/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Fractured Left Hip
Fractured Right Hip Not Pinned | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3:30 P.M. Feb 8, 1984 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Fell at Home
Fell in Hospital PT-Dept | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (IN HOME
(FREE-LEAD COPY, FARM, ETC.)
Home | | 21f. LOCATION
(FREE-LEAD COPY, CITY OR TOWN, COUNTY, STATE)
527 Park Ave Towson Balto in
St Joseph Hosp - Old Towson Balto Md | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE
Chadest Onouall | | TITLE (SPECIFY)
Deputy | | | | MEDICAL EXAMINER | | DATE
SIGNED 3/8/84 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-12-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pikesville Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. | | ADDRESS
Towson, Md. 21204 | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1984 | | 25b. REGISTRAR'S SIGNATURE
John P. ... | | | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06509

REG. NO.

daylight savings

1. FOR
STATE
REGISTRAR

1. DECEASED NAME

FIRST

MIDDLE

LAST

Henry
DONALD, SONNENLEITER

2a. DATE OF DEATH

MONTH

DAY

YEAR

3-26-84

2b. HOUR

2:15 P.M.

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

Aug. 23, 1930

6. AGE (IN YEARS LAST BIRTHDAY)

53

IF UNDER 1 YEAR
MONTHS DAYS

IF UNDER 24 HRS.
HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE COUNTY MD.

10. CITY OR TOWN OF DEATH

TOWSON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

ST. JOSEPH HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Chauffeur

12b. KIND OF BUSINESS OR INDUSTRY

B.G. & E.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

2561 Southdene Avenue, 21230

14. FATHER'S NAME

Albert

MIDDLE

LAST

Sonnenleiter

15. MOTHER'S MAIDEN NAME

Bessie

MIDDLE

Bertha

LAST

Hartman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

216-24-4809

17. INFORMANT

Ruth F. Sonnenleiter Same as #13

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

4275

IMMEDIATE CAUSE (a)

Cordian arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Cardiogenic shock

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Pneumonia, stroke, Renal Failure

19a. DATE OF OPERATION

2-29-84

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Mitral valve dysfunction

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last

saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

Dr. Taylor M.D.

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

3-26-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. A. Taylor

22e. ADDRESS

M.D.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

3/30/1984

23c. NAME OF CEMETERY OR CREMATORY

Meadowridge Mem. Pk.

23d. LOCATION

CITY OR TOWN

COUNTY

Elkridge, Howard Co., Md.

STATE

24. FUNERAL DIRECTOR

McCully Funeral Homes

Balto., Md., 21225

237 E. Patapsco Ave.,

25a. DATE REC'D. BY REGISTRAR

MAR 29 1984

SIGNATURE OF REGISTRAR

John Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

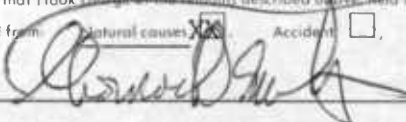
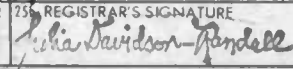
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

7-10-1900

ADD RS RAY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 6510 | | | |
|--|--|------------------|---|---|---|---|---|---|---|---|--|------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Mabel B. Sparrow | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
3-30 1984 | | 2b. HOUR
12:03 p.m. | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 4 20 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
63 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3-30 1984 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore County General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Woodlawn | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
21207
7107 Rudisill Ct. Apt. 2A | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lewis A. Harris | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora V. Dawson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | | 16b. SOCIAL SECURITY NO.
212-28-1982 | | 17. INFORMANT ADDRESS
Apt. 3A
Cora Tucker 7051 Rudisill Ct. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Deputy Chief | | | | DATE SIGNED
3-31-84 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
4/3/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Pk | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | | | ADDRESS
1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
APR 2 1984 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR MARIA AUGUSTA SPRINGHAM | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARIE AUGUSTA SPRINGHAM | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
03 13 84 | | | 2b. HOUR
6 ⁰⁰ A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
3 7 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH
ROSSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MANOR CARE ROSSVILLE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
DUNDALK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7018 MORNINGTON ROAD 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
HARRY Reinhold | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
AGNES CUMMINGS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
213.74.4990 | | 17. INFORMANT ADDRESS
C. WILLIAM SPRINGHAM, JR. 1707 MELBOURNE RD. DUNDALK, MD. 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident
4360 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cerebro-vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
few hrs.
yrs. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from 10/5/1982 to 3/13/1984, that (we) last saw the deceased alive on 3/13/1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
W. J. Tun | | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
3/13/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. Tun | | | 22e. ADDRESS
Manor Care Rossville md 21237 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
3/16/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR
WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 | | | | | 25. DATE REC'D. BY REGISTRAR SIGNATURE
MAR 15 1984 J. Davidson | | | | |

Arteriosclerosis cerebri-vascular
Cerebro-vascular accident

10-27-84

M.D. X
2/12/84

3/13/84 - 3/12/84

3/13/84 - 3/12/84

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06512

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CHARLES Walter Spudeck Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 16 84 | | | 2b. HOUR
9:00AM | | | |
| 3. SEX
male | | 4. RACE
white (Cauc) | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 26 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Towson, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Joseph Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
GAS & Oil Merchant | | 12b. KIND OF BUSINESS OR INDUSTRY
Steel | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1825 Kinslip Rd., 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES WALTER Spudeck Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JO ANNA Mieronowicz | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES 1941-1945 | | 16b. SOCIAL SECURITY NO.
191-01-9832 | | 17. INFORMANT
PTG. Hospital, Mary + Sister, Genevieve Edelman | | ADDRESS
4015 Taylor Ave Balto, Md 21236 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardio respiratory arrest due to

DUE TO, OR AS A CONSEQUENCE OF

(b) **liver failure secondary to**

DUE TO, OR AS A CONSEQUENCE OF

(c) **liver metastasis from primary cancer of rectum**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **1541**

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Frederick White | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-16-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
St. Joseph Hospital | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|--|--|-------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/20/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PARKVILLE BALTO. MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
GIPPEL FUNERAL HOME'S INC 7110 BELAIR RD BALTIMORE MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 19 1984 [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified.

10/11/11

Dear Sir,
I have the pleasure to inform you that
the same has been forwarded to you
by the same.

Yours faithfully,
[Signature]

Very truly yours,
[Signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06513

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|---|--|---|--|--|---------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edward Clay Stambaugh, Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 28, 1984 | | | 2b. HOUR
M | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
3 01 1911 | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 8b. CITIZEN OF WHAT COUNTRY?
U.S. | 8c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County, MD | | | | |
| 10. CITY OR TOWN OF DEATH
Lutherville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
517 Ridewood-Lutherville Drive | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner | | 12b. KIND OF BUSINESS OR INDUSTRY
Refuse Service | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Balti. | | 13c. CITY OR TOWN
Lutherville | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elmer Stambaugh | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Naomi Johnson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-01-2949 | | 17. INFORMANT
ADDRESS
Anna A. Stambaugh Same | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

4100 IMMEDIATE CAUSE (a) Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Several days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Carcinoma of urinary bladder.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 5/17, 1976, to 3/28, 1984, that (b) (we) lost
saw the deceased alive on 2/28, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Alberto J. Diaz | | DEGREE
MD | | ATTENDING
PHYSICIAN <input checked="" type="checkbox"/> MEDICAL
DIRECTOR <input type="checkbox"/> STAFF
PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-29-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alberto J. Diaz, M.D. | | | | 22e. ADDRESS
7600 Osler Drive; Towson, MD 21204 | | | |

| | | | |
|---|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/31/84 | 23c. NAME OF CEMETERY OR CREMATORY
Fairview | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Jacksonville, Balto. Co., Md. |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. | | ADDRESS
6500 York Rd. Balto., Md. 21212 | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1984 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STG 1, 1972

STG 2, 1972

STG 3, 1972

STG 4, 1972

STG 5, 1972

STG 6, 1972

STG 7, 1972

STG 8, 1972

STG 9, 1972

STG 10, 1972

STG 11, 1972

STG 12, 1972

STG 13, 1972

STG 14, 1972

STG 15, 1972

STG 16, 1972

STG 17, 1972

STG 18, 1972

STG 19, 1972

STG 20, 1972

STG 21, 1972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|-----------|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| | | | FIRST MIDDLE LAST | | 3-5-84 | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| male | | | W | | 07/03/05 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MD | | | U.S. | | 78 YRS. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore | | | St. Joseph's Hospital 6700 | | Baltimore County MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) (2c. STATE) | | | 13b. COUNTY | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| MD | | | BALTO | | WARNER Paper Co. Purch. Agt. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 12c. STREET ADDRESS / ZIP CODE | |
| Charles Edward Staylor | | | Ida Bryan | | 2447 Ellis Avenue 21234 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | 214-03-3033 | | Charles A. Staylor R1 Box 460 Chester, Md. 21619 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | |
| IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma | | | | | | |
| 1991 DUE TO, OR AS A CONSEQUENCE OF (b) of liver | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 7 months | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-24-84 to 3-5-84, that (I) (we) last saw the deceased alive on 3-5-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED |
| A.H. Ghiladi | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 3-5-84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | |
| A.M. GHILADI, M.D. | | | 7600 OSLER Dr Towson 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Entombment | | 3/9/84 | | Dulaney Valley Maus. | | Cockeysville Md. |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR (BY REGISTERED DEATH INVESTIGATOR) | | |
| Mitchell-Wiedefeld | | | | 4/8/84 | | |
| ADDRESS | | | | MAR 6 1984 | | |
| 6500 York Rd. | | | | | | |

INDEX

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "INDEX" and "TABLE" are visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EVELYN MARIE STERNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAR 19, 1984 | | | 2b. HOUR
7:22 M | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
11/1/17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
ESSEX | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
36 CLIPPER RD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HSWE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
ESSEX | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
36 CLIPPER RD | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HOWARD SULLENS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARIE KRALL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213 01 6142
212 073931 | | 17. INFORMANT
ADDRESS
JOE KONOPACKI | | | | A BOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerotic heart disease | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Rheumatoid Arthritis with involvement of cardiac conduction system | | | | | | | | | |
| 19a. DATE OF OPERATION
7/23/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
SP Pacemaker insertion >10 yrs | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
1576 merrill Blvd, Balto Md 21222 | | CITY OR TOWN
BALTO | | COUNTY
MD | |
| 22a. I certify that (1) (this hospital) attended the deceased from July 1973 to 3/19/84 , that (1) (we) last saw the deceased alive on 1/23/84 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert L. Marcus, MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
3/20/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert L. Marcus | | | | 22e. ADDRESS
1576 merrill Blvd, Balto Md 21222 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/22/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 23d. LOCATION
CITY OR TOWN
BALTO | | COUNTY
MD | |
| 24. FUNERAL DIRECTOR
NAME
J.G. CONNELLY | | | | ADDRESS
300 MACE | | 25a. DATE REC'D. BY REGISTRAR
MAR 21 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendell | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|---------|---|------------------|--|---------------------------------|--|---|-----------------------------------|--------------------------------|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Margaret Adele STEVENS | | | | | March 29, 1984 | | | | | 4:03P M | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Female | White | | June 19 1896 | | 87 | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Rossville 21237 | | Franklin Sq. Hospital | | | | Housewife | | Home | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | |
| Maryland | | | Baltimore | | Middle River | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 304 Harding Ave. 21220 | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST
Cornelius Johnson | | | | FIRST MIDDLE LAST
Mary Jane | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 218 22 4688 | | John Peyton | | 7346 Hughes Ave 21219 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardio Respiratory Arrest. Large left**
4275 DUE TO, OR AS A CONSEQUENCE OF **Pleural Effusion**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) _____
 DUE TO, OR AS A CONSEQUENCE OF
 (c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 21</u> , 19 <u>84</u> , to <u>March 29</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>March 29</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| <i>Fernando J. Acle, M.D.</i> | | | | | | 3-29-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Fernando J. Acle, M.D. | | | | 9000 Franklin Square Dr., 21237 | | | |

| | | | |
|---|-----------|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| Burial | 4/2/84 | Lion Luth. Ch. Cemetery | Baltimore Co., Md. |
| 24. FUNERAL HOME | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Grudzinski Funeral Home PA Baltimore, Md. 21222 | | APR 2 1984 | <i>Lia Davidson-Randall</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|---|---|--|--------------------------------|--|--|--|-------|--|-------|--|----------|--|------|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | MIN. | | | | | | | | | | | |
| WILLIAM | | D. | | STROBEL | | | | 3 | | 21 | | '84 | | 4:00A | | M | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | | | | | | | | | | | | | |
| MALE | | WHITE | | JUNE 21, 1898 | | 85 | | MONTHS | | DAYS | | HOURS | | MIN. | | | | | | | | | | | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| MARYLAND | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | BALTIMORE COUNTY | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | |
| TOWSON | | GBMC-6701 N. CHARLES ST. | | BOTTLER | | SUBURBAN | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | | | | | | | | | | | | | |
| MARYLAND | | BALTIMORE | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 600 LIGHT STREET 21230 | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WILLIAM | | KATIE | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | |
| NO | | 212-18-9313 | | FAMILY RECORDS | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | CARDIOPULMONARY FAILURE | | | | | | | | | | | | | | | | | | | |
| 4860 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | PNEUMONIA | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | 3/09 TO 3/21 '84 | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | |
| | | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| AT WORK AT WORK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/09, 19 84, to 3/21, 19 84, that (I) (we) last saw the deceased alive on 3/21, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| Michael Joyce | | | | | | | | | | M.D. | | | | | 3/21/84 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| MICHAEL JOYCE, M.D. | | | | | | | | | | GBMC-6701 N. CHARLES ST. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION | | | | | | | | | | | | | | |
| Burial | | | | | MARCH 23 1984 | | | | | LOUDON PARK CEM. | | | | | BALTIMORE MARYLAND | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| NAME | | | | | | | | | | MAY 2 1984 | | | | | | | | | | R. J. ... | | | | | | | | | |
| Evans Chapel of Memories | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

BP

3 21 184 4:00A

82

M LE

BALTIMORE COUNTY

GBMC-6701 N. CHARLES ST.

TOWSON

CARDIOPULMONARY FAILURE

PNEUMONIA

3/09 TO 3/21
1984

X

84

3/21

84

3/09

84

3/21

3/21/84

GBMC-6701 N. CHARLES ST.

MICHAEL JOYCE, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

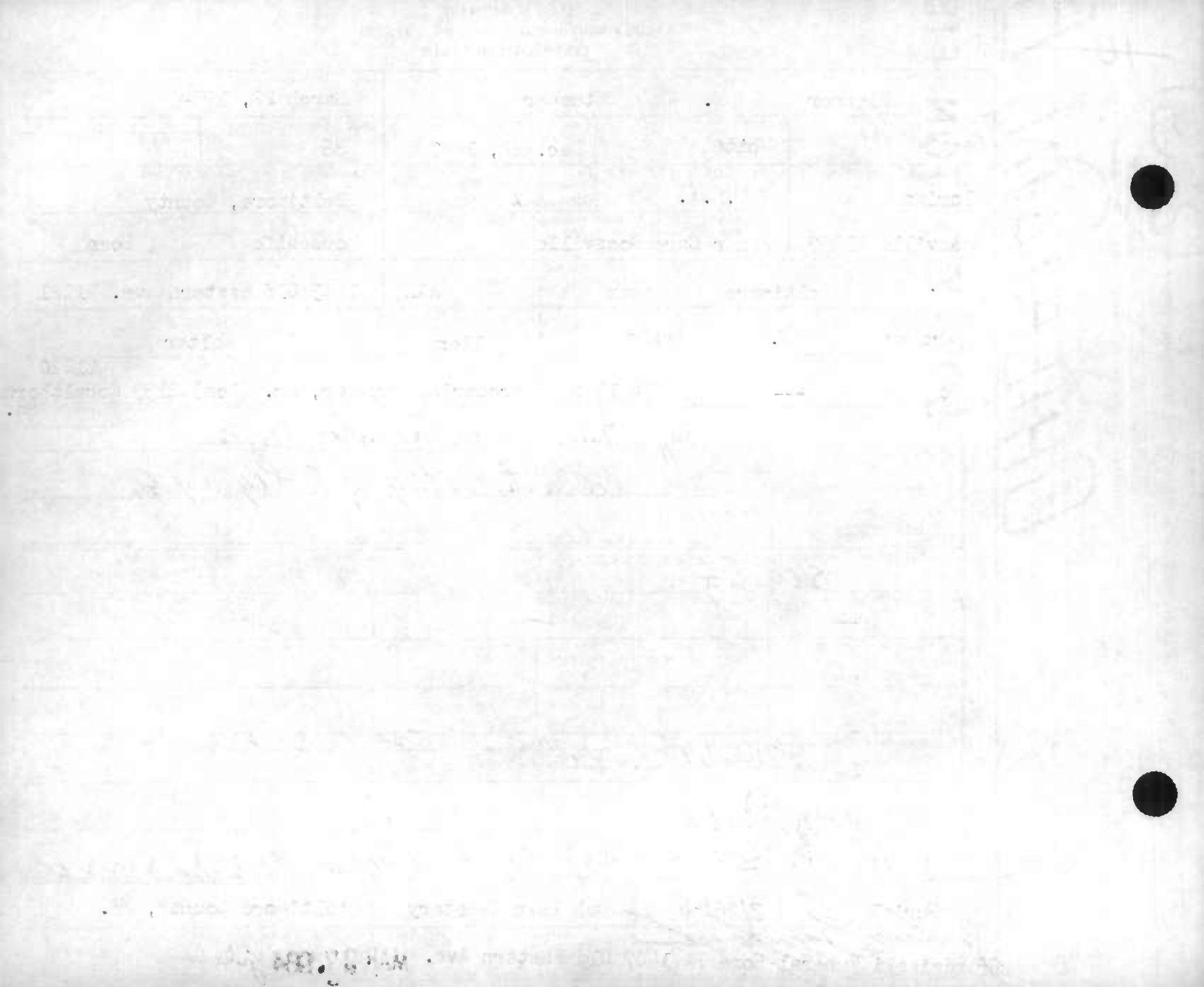
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Eleanor E. Stueber | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 22, 1984 | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 22, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Florida | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rossville 21237 | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Manor Care Rossville | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Essex | | 13e. STREET ADDRESS
1023 Old Eastern Ave. 21221 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur T. Renno | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellen Walter | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO.
216 34 1380 | | 17. INFORMANT ADDRESS
Frederick Stueber, Jr. (Son) 2133 Coralhorn | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c).
PART I. DEATH WAS CAUSED BY:
4029 Hypertensive Cardiovascular Disease
IMMEDIATE CAUSE (a) Cellulitis - stump of R leg amputated
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Semiblight | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 52 , to March 16 84 , that (I) (we) last saw the deceased alive on March 16 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Irving R. Beck MD | | | | | DEGREE
MD | | | 22c. DATE SIGNED
March 27, 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
IRVING R. BECK MD | | | | | 22e. ADDRESS
901 Funderburg Rd. Balt. Md 21220 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/26/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore County, Md. | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 27 1984 | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Stella Jean Stulich | | | 2a. DATE OF DEATH
MONTH 3 DAY 24 YEAR 84 | | | 2b. HOUR
6:00 A M | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 4 DAY 15 YEAR 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Dundalk | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3433 Cornwall Rd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Tailor | | | 12b. KIND OF BUSINESS OR INDUSTRY
Botany 500 | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
3419 Dunhaven Road 21222 | | |
| 14. FATHER'S NAME
FIRST Sigmund MIDDLE LAST Lepkowski | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Josephine MIDDLE LAST Not Known | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
216-10-8210 | | 17. INFORMANT
Paul M. Stulich | | | ADDRESS
3433 Cornwall Road Balto. MD 21222 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**1539
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Metastatic Cancer Colon**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7 19 85 , to 2 19 84 , that (I) (we) lost saw the deceased alive on 2 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Myo Thant | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/24/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Myo Thant | | 22e. ADDRESS
4101 FRANKLIN SO. DR BALTO. MD 21237 | | | | | |

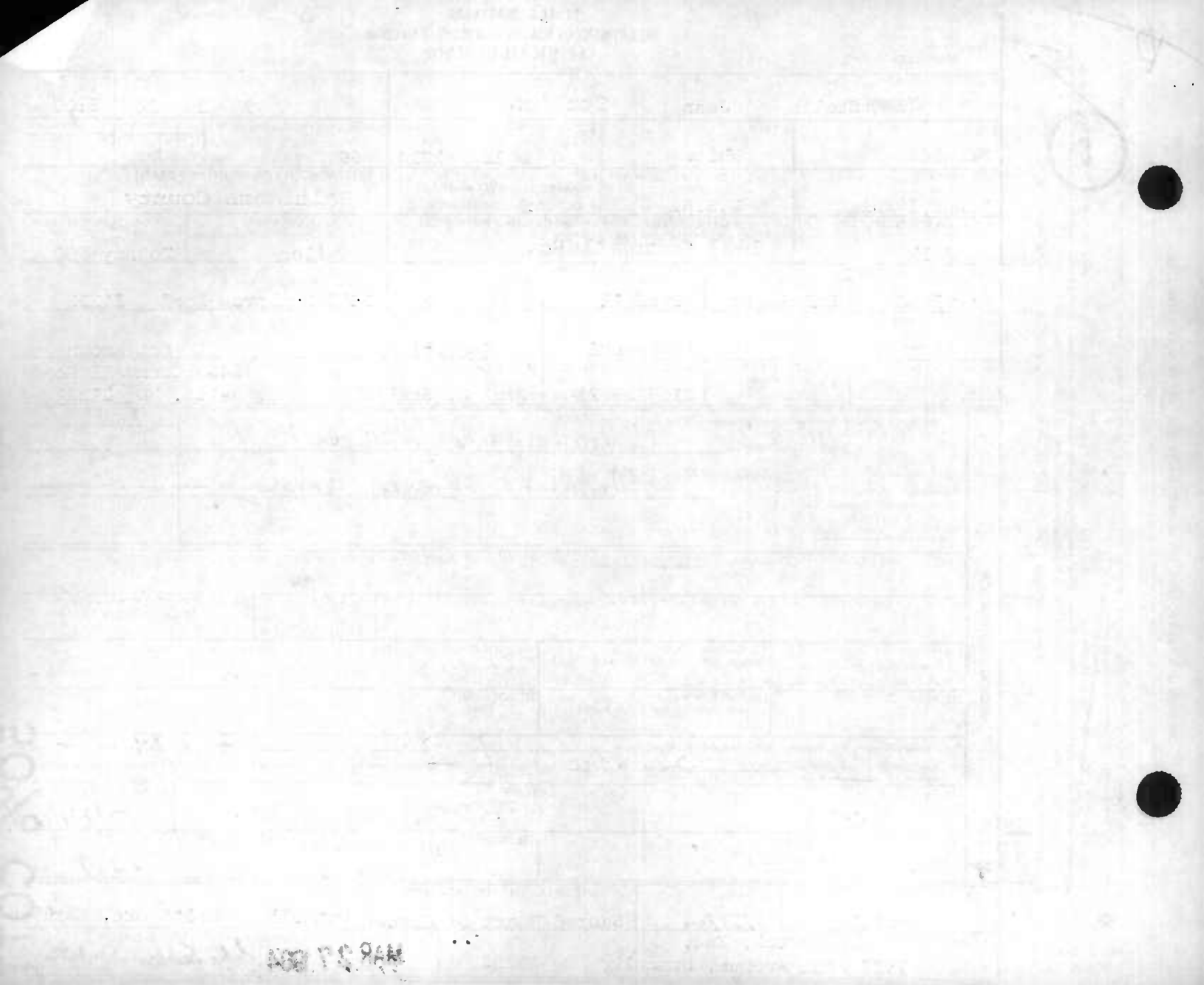
| | | | | | | | |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
3/27/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | | 23d. LOCATION
CITY OR TOWN Dundalk COUNTY Baltimore STATE Maryland | |
| 24. FUNERAL DIRECTOR Duda-Ruck, Inc.
NAME ADDRESS
7922 Wise Avenue, Dundalk, MD 21222 | | | | 25a. DATE REC'D. BY REGISTRAR MAR 27 1984 25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



MELLIN CC001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARIE TARVER | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/13/84 | | 2b. HOUR
8:40 AM | |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
9 23 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ALABAMA | 7b. CITIZEN OF WHAT COUNTRY?
US | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BALTIMORE COUNTY GEN. HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK HENDRICKS SR. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JULIA MARSHALL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
HENRY TARVER 3517 LYNCHESR ROAD 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 2° to acute
4919 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which } (b) respiratory failure 2° to chronic
gave rise to immediate }
cause (a), stating the }
underlying cause last. } (c) Bronchitis | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
SLP (R) Pneumectomy for Fibrosis 2° to Radiation Bx Hodgkin's granuloma. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12/84, 1984, to 3/13/84, 1984, that (I) (we) lost
saw the deceased alive on 3/13/84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
R.M. Shah, M.D. | | | | 22c. DATE SIGNED
3/13/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R.M. SHAH, M.D. | | | | 22e. ADDRESS
OLD COURT RD & LIBERTY RD
Randallstown, MD. 21133 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
REMOVAL | | 23b. DATE
3-18-84 | | 23c. NAME OF CEMETERY OR CREMATORY
MARSHALL CENT. | |
| 24. FUNERAL DIRECTOR
NAME
E.L. PHILLIPS | | 1721 N. MONROE ST. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
MONTGOMERY ALABAMA | |
| 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE
MAR 14 1984 Julia Davidson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANNE K. TAYLOR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 9 84 | | 2b. HOUR
245 AM |
| 3. SEX
Female | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
1 29 07 | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Square Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SEAMSTRESS | | 12b. KIND OF BUSINESS OR INDUSTRY
TAILORING CO. |
| 13a. STATE
MD. | | 13b. COUNTY
HARFORD | 13c. CITY OR TOWN
FALLSTON | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PETE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAGGIE KARTANJCIA | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
220-20-8279 | | 17. INFORMANT
ADDRESS
ROBT. TAYLOR (SON) SAME ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1830 Cardiopulmonary Arrest, Acute Renal Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Ovarian Cancer
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (he) (this hospital) attended the deceased from February 25, 1984, to March 9, 1984, that (I) (we) last saw the deceased alive on March 9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S SIGNATURE
I. Rodriguez, M.D. | | DEGREE
MD | | 22c. DATE SIGNED
3/9/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
I. Rodriguez, M.D. | | 22e. ADDRESS
9000 Franklin Sq. Dr., 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/12/84 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD | |
| 23d. LOCATION
CITY OR TOWN
BALTIMORE | | COUNTY
MD. | | STATE | |
| 24. FUNERAL HOME
NAME ADDRESS
SIMONEK FUNERAL HOME, INC.
9705 BELAIR RD., BALTO MD. 21236 | | | | 25. DATE REC'D. BY REGISTRAR
MAR 12 1984 | |
| | | | | 25. REGISTRAR'S SIGNATURE
[Signature] | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, always enter injury or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

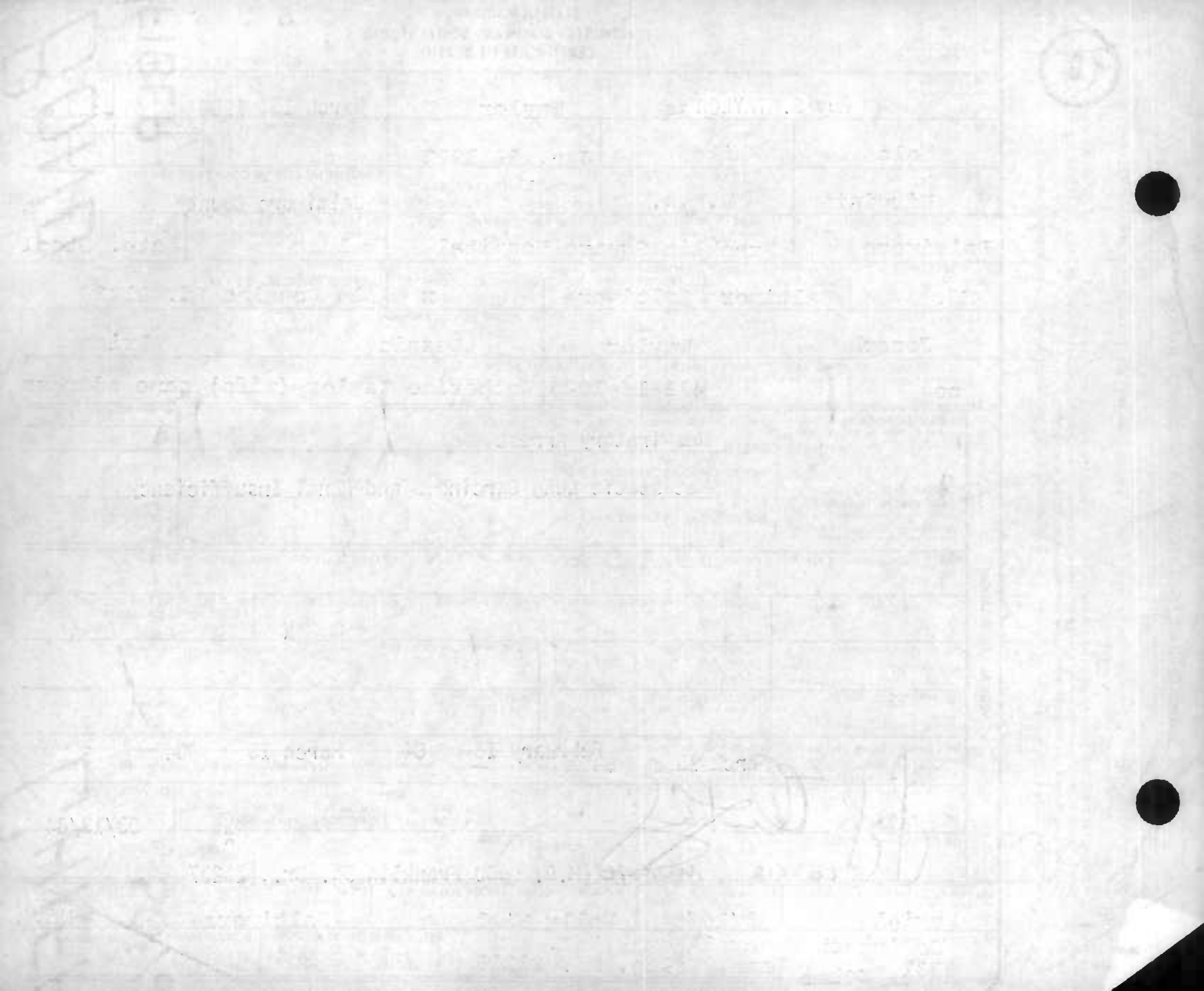
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Roy Silas Taylor Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 13, 1984 | | | 2b. HOUR
3:10 a.m. | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 28 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Square Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Welder | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STATE
Md. | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
14 Douglas Rd. 21220 | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Taylor | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Price | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
413-16-1023 | | | 17. INFORMANT ADDRESS
Katherine Taylor (wife) same address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Lung Carcinoma and Renal Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from February 16, 1984 to March 13, 1984 , that (H) (we) last saw the deceased alive on March 13, 1984 , and that in (our) opinion death occurred on the date and hour and from the causes stated above (H) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i>
DEGREE | | | | | | 22c. DATE SIGNED
03/13/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LESCIE MORAN, M.D. | | | | | | 22e. ADDRESS
9000 Franklin Sq. Dr., 21237 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/16/84 | | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1984 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | | | | |

BP _____

H - 16 50M 4/83
VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | |
|--|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JOSEPH TEMPERA | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 29 84 | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
12 18 14 | | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
69 YRS | | 2b. HOUR
3 45 PM |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
Woodlawn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1601 FOREST PARK AVENUE, 21207 | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RECREATION/PARKS | | 12b KIND OF BUSINESS OR INDUSTRY
CITY OF BALTIMORE | |
| 13a STATE
MARYLAND | | | 13b COUNTY
BALTIMORE | | 13c CITY OR TOWN
1601 FOREST PARK AVENUE, 21207 | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
EVANDRO A. TEMPERA | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | 16b SOCIAL SECURITY NO.
UNAVAILABLE | | 17. INFORMANT ADDRESS
RICK TEMPERA 1601 FOREST PARK AVE., 21207 | | | |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) 5990 probably Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) decubitus ulcer.
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic urinary tract infection
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
comatose due to multiple CVA's.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4 19 82 to 3/29 19 84 , that (I) (we) lost saw the deceased alive on 3/29 19 84 , and that (I) (we) (our) apian death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/29/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael D. Albuverne | | | | 22e. ADDRESS
St. Agnes Hosp. | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
04-02-84 | | 23c. NAME OF CEMETERY OR CREMATORY
CREST LAWN MEM. GAR. | | 23d LOCATION CITY OR TOWN COUNTY STATE
MARRIOTTSTVILLE HOWARD MD. | | |
| 24 FUNERAL DIRECTOR NAME
HUBBARD FUNERAL HOME, INC. | | | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
APR 2 1984 | | 25b. REGISTRAR'S SIGNATURE
[Signature] |

3 24 84 242



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director/page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. 06524 | | | | |
|---|--|--|--|---|---|---|--|--|---|--|---|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Elend THEODOSIOS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 13, 1984 | | | | | 7b. HOUR
11:35am
M | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
4 23 11 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Greece | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | | | |
| 11. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Square Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
702 S. Umbra Street 21224 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Marti Koutsoudakis | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Filia | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]
No | | | | | 16b. SOCIAL SECURITY NO.
081-03-1080 | | 17. INFORMANT ADDRESS
Ted Theodosios, 9010 Moonstone Road
Baltimore, Md. 21236 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 3481
DUE TO, OR AS A CONSEQUENCE OF (b) Anoxic Encephalopathy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.
Renal Failure, Sepsis, Diabetes Mellitus | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from February 23, 1984, to March 13, 1984, that (I) (we) lost saw the deceased alive on March 13, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
J E Nelson | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-13-84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J E Nelson | | | | 22e. ADDRESS
9000 Franklin Square Drive 21237 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
3-16-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Greek Orthodox Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR
Nicholas T. Matthews, 3021 Eastern Avenue
Baltimore, Md. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 15 1984 Julia Davidson-Randall | | | | |

BP

FILED

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TIME

LOCATION

NAME

STATUS

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16-12-91

TE Nelson

DATE

TIME

LOCATION

NAME

STATUS

REMARKS

DATE

TIME

LOCATION

NAME

STATUS

REMARKS

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06525

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Margaret Taylor Thompson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 - 28 - 84 | | | 2b. HOUR
4:00 A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 13 1882 | | 6. AGE (IN YEARS LAST BIRTHDAY)
101
YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, County MD. | |
| 10. CITY OR TOWN OF DEATH
Stevenson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baptist Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Telephone Solic. | |
| | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Parkville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Taylor | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sallie Miles | | 13e. STREET ADDRESS / ZIP CODE
4508 Elsröde Ave. 21214 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-36-7329 | | 17. INFORMANT
ADDRESS
Mrs. Florence Powerscx, 9305 Avondale Rd. 21234 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

3310

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Atherosclerotic Cardiovascular Disease

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
→ | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 82 to March 19 84, that (I) (we) lost
saw the deceased alive on 3-22-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John G. Lavin | | DEGREE
MD | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN DIRECTOR PHYSICIAN | | 22c. DATE SIGNED
3-28-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John G. Lavin | | 22e. ADDRESS
6805 York Road 21212 | | | | | |

| | | | | | | | |
|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-30-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Western | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home 6500 York Road 21212 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 30 1984 John Davidson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

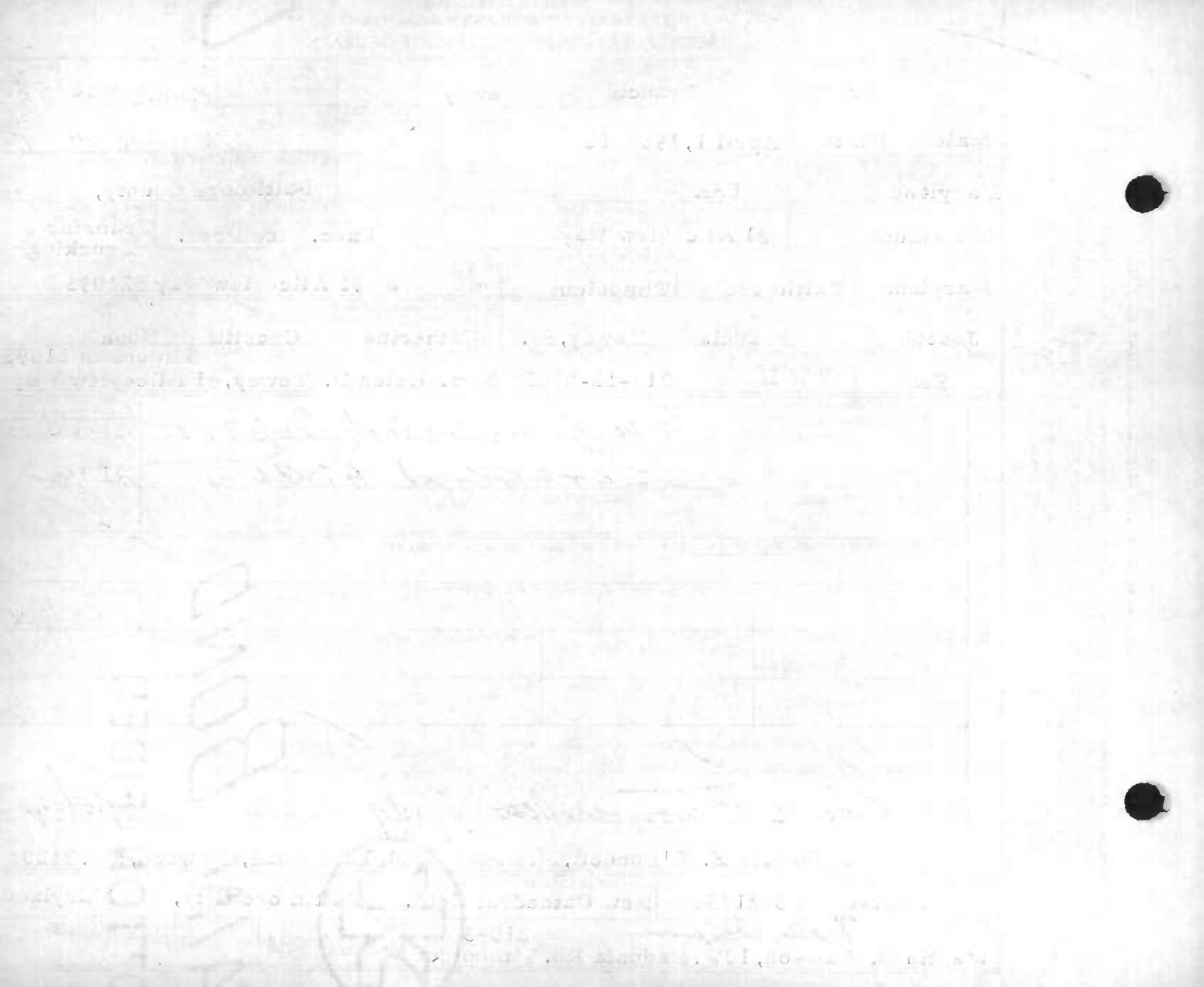
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|----------------------|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Joseph Francis Tewey | | | 2a. DATE KNOWN OF DEATH ESTIMATED March 18, 1984 | | 2b. HOUR 5 PM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH
MONTH DAY YEAR April 1, 1920 | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD March 18, 1984 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Timonium | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) #1 Aliceview Way | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. Vice Pres. | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Timonium | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Joseph Francis Tewey, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Catherine Ceceilia Noon | | 17. INFORMANT ADDRESS Timonium 21093 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW II 215-12-8783 | | 17. INFORMANT ADDRESS Mrs. Helen D. Tewey, #1 Aliceview Way | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4100 Acute Myocardial Infarct
IMMEDIATE CAUSE (a) Sudden
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Generalized Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) 2+ yrs | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell, M.D. | | TITLE (SPECIFY) Deputy Medical Examiner | | DATE SIGNED 3/18/84 | |
| EXAMINER'S NAME
(TYPE OR PRINT) Charles F. O'Donnell, M.D. | | ADDRESS 7501 York Road, Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE 3/21/84 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | |
| 23d. LOCATION
CITY OR TOWN Baltimore City, | | COUNTY Maryland | | STATE | |
| 24. FUNERAL DIRECTOR
NAME Martin D. Lawson | | ADDRESS 21093 | | 25a. DATE REC'D. BY REGISTRAR MAR 20 1984 | |
| 25b. REGISTRAR'S SIGNATURE Gutha Davidson-Randall | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06521

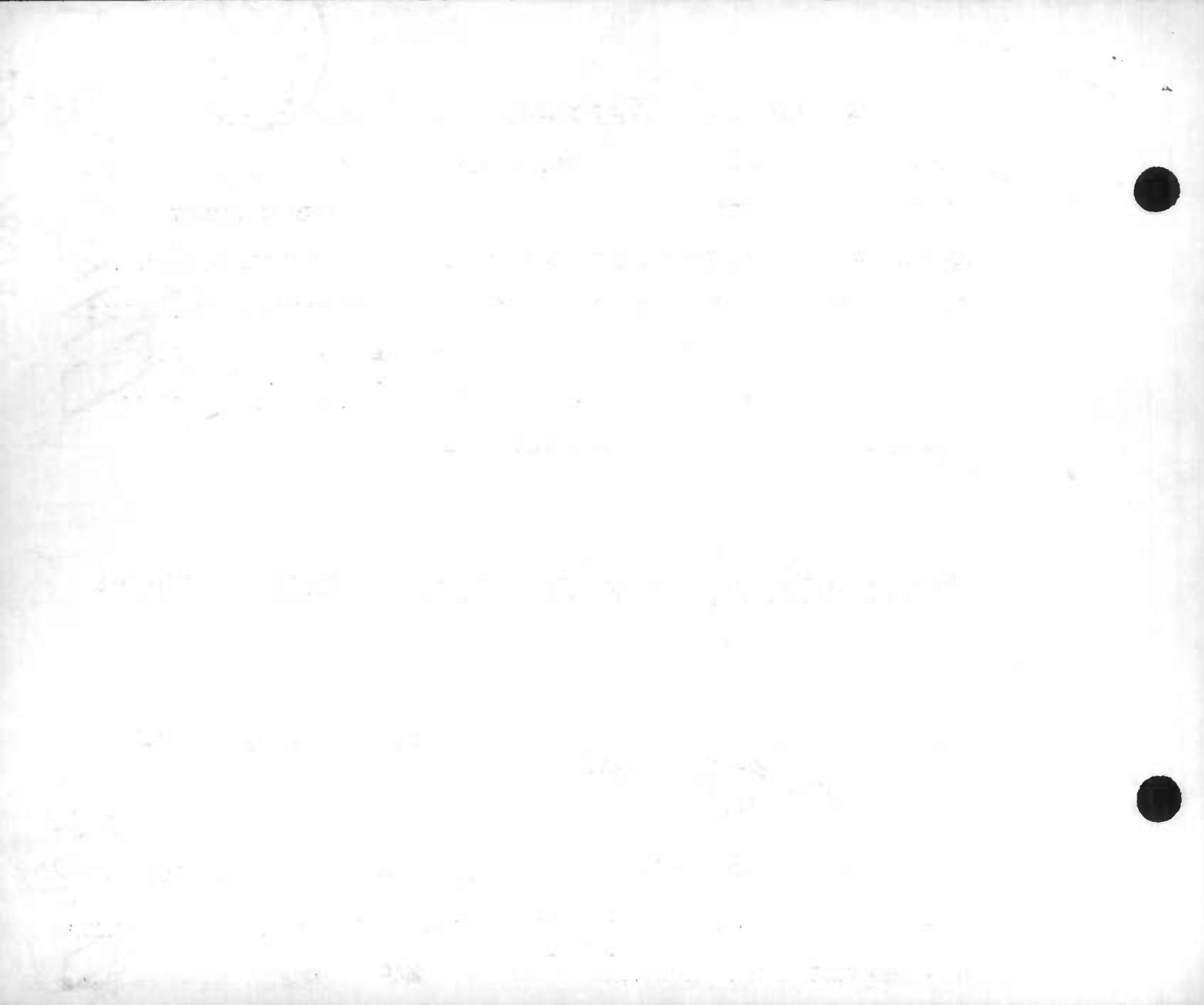
| FOR STATE REGISTRAR | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HAROLD PAUL TIETZER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 2, 1984 | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 1, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
72 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BALTIMORE COUNTY GEN. HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
POSTAL CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. POST OFFICE | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
AARON TIETZER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FANNIE SCHASS | | 13e. STREET ADDRESS / ZIP CODE
3708 KINGWOOD SQ. #21215 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII-ARMY 220-05-7725 | | 17. INFORMANT
ADDRESS
MRS. EDITH S. TIETZER | | 17. INFORMANT
ADDRESS
3708 KINGWOOD SQ. BALTO., MD 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4860 IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)
NON-KETOIC HYPEROSMOLAR COMA, DIABETES MELLITUS, OLD CEREBRAL-VASCULAR ACCIDENT w/ CONTRASTURES | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-1 19 84 , to 3-2 19 84 , that (I) (we) last saw the deceased alive on 3-2 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Orlando B. Conway, MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-2-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ORLANDO B. CONWAY, MD | | 22e. ADDRESS
BCEH RANDALLSTOWN MD. 21133 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(b) BURIAL | | 23b. DATE
MAR. 4, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH YEHUDA ANSHE KURLAND | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 6 1984 | | 25b. REGISTRAR'S SIGNATURE
Orlando B. Conway | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the hospital death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|-------------------------|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Clarence William Tolbert | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
3/25 1984 | | 2b. HOUR
MIN
6P |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug 10, 1904 | 6. AGE (IN YEARS)
LAST BIRTHDAY
79 YRS. | IF UNDER 1 YR.
MONTHS DAYS
3/25 | IF UNDER 24 HRS.
HOURS MIN
6P |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
339 Sassafras Road, 21221 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Mechanic | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David Tolbert | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nancy Nunn | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
233-09-7714 A | | 17. INFORMANT
ADDRESS
Balto. Md. 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Respiratory Failure
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) ASVD 2000 CVA
(c) Pulmonary Embolism | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
Pulmonary Embolism | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
Theodore C. Patterson | | TITLE (SPECIFY)
MD | | MEDICAL EXAMINER
DATE SIGNED 3/25/84 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Theodore C. Patterson, MD | | ADDRESS
3427 Dundalk Ave., Balt. 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/28/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Bland Cemetery | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck | | ADDRESS
Inc. Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 29 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

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100 200 300 400 500 600 700 800 900 1000

100 200 300 400 500 600 700 800 900 1000

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06529

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
GEORGE A. TORNEY, Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 30, 1984 | | 2b. HOUR
2:45 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1-11-14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
TOWSON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Foreman Armco Steel | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George A. Torney, Sr. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cecelia F. Piller | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
212-05-6902 | | 17. INFORMANT
ADDRESS
Eva M. Torney, Same as 13e' | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

2028 IMMEDIATE CAUSE (a) **LYMPHOMA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (X) (this hospital) attended the deceased from 2-29 , 19 84 , to 3-30 , 19 84 , that X (we) lost
saw the deceased alive on 3-30 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (X) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Beatriz P. Dizon, M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
3/30/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Beatriz P. Dizon, M.D. | | 22e. ADDRESS
7620 York Road Towson Md 21204 | |

| | | | |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
4-1-84 | 23c. NAME OF CEMETERY OR CREMATORY
Bel Air Memorial | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bel Air, Md. |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
APR 3 1984 <i>Tha Davidson-Rendell</i> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



George A. ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mrs. Elsie V. Tracy | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 7 1984 | | | 2b. HOUR
11¹⁰ AM | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 12 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore County General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
George Ruehl Co | |
| 13a. STATE
Maryland | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Eldersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
6210 West Hemlock Drive 21784 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Cecil Caples | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Bowers | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
219-14-1088 | | 17. INMATE ADDRESS
Mr. Charles E. Tracy Sr. 21784
6210 West Hemlock Drive Eldersburg Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
4100
DUE TO, OR AS A CONSEQUENCE OF, WITH
(b) CARDIOGENIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF, WITH
(c) PULMONARY EDEMA.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
ARTERIOSCLEROTIC HEART DISEASE, OLD CEREBRO-VASCULAR ACCIDENT. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-29-1984 , to 3-7-1984 , that (I) (we) last saw the deceased alive on 3-7-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3-7-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. SUDHIR D. PATEL | | | | 22e. ADDRESS
BAL. COUNTY GEN. HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-10-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Finksburg Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Finksburg Carroll Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, Maryland 21133 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 9 1984 | | 25b. REGISTRAR'S SIGNATURE
Juha Davidson-Rendell | | | |



| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1954 | | 1955 | | 1956 | | 1957 | | 1958 | | 1959 | | 1960 | | 1961 | | 1962 | | 1963 | | 1964 | | 1965 | | 1966 | | 1967 | | 1968 | | 1969 | | 1970 | | 1971 | | 1972 | | 1973 | | 1974 | | 1975 | | 1976 | | 1977 | | 1978 | | 1979 | | 1980 | | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | | 1987 | | 1988 | | 1989 | | 1990 | | 1991 | | 1992 | | 1993 | | 1994 | | 1995 | | 1996 | | 1997 | | 1998 | | 1999 | | 2000 | | 2001 | | 2002 | | 2003 | | 2004 | | 2005 | | 2006 | | 2007 | | 2008 | | 2009 | | 2010 | | 2011 | | 2012 | | 2013 | | 2014 | | 2015 | | 2016 | | 2017 | | 2018 | | 2019 | | 2020 | | 2021 | | 2022 | | 2023 | | 2024 | | 2025 | | 2026 | | 2027 | | 2028 | | 2029 | | 2030 | | 2031 | | 2032 | | 2033 | | 2034 | | 2035 | | 2036 | | 2037 | | 2038 | | 2039 | | 2040 | | 2041 | | 2042 | | 2043 | | 2044 | | 2045 | | 2046 | | 2047 | | 2048 | | 2049 | | 2050 | | 2051 | | 2052 | | 2053 | | 2054 | | 2055 | | 2056 | | 2057 | | 2058 | | 2059 | | 2060 | | 2061 | | 2062 | | 2063 | | 2064 | | 2065 | | 2066 | | 2067 | | 2068 | | 2069 | | 2070 | | 2071 | | 2072 | | 2073 | | 2074 | | 2075 | | 2076 | | 2077 | | 2078 | | 2079 | | 2080 | | 2081 | | 2082 | | 2083 | | 2084 | | 2085 | | 2086 | | 2087 | | 2088 | | 2089 | | 2090 | | 2091 | | 2092 | | 2093 | | 2094 | | 2095 | | 2096 | | 2097 | | 2098 | | 2099 | | 2100 | | 2101 | | 2102 | | 2103 | | 2104 | | 2105 | | 2106 | | 2107 | | 2108 | | 2109 | | 2110 | | 2111 | | 2112 | | 2113 | | 2114 | | 2115 | | 2116 | | 2117 | | 2118 | | 2119 | | 2120 | | 2121 | | 2122 | | 2123 | | 2124 | | 2125 | | 2126 | | 2127 | | 2128 | | 2129 | | 2130 | | 2131 | | 2132 | | 2133 | | 2134 | | 2135 | | 2136 | | 2137 | | 2138 | | 2139 | | 2140 | | 2141 | | 2142 | | 2143 | | 2144 | | 2145 | | 2146 | | 2147 | | 2148 | | 2149 | | 2150 | | 2151 | | 2152 | | 2153 | | 2154 | | 2155 | | 2156 | | 2157 | | 2158 | | 2159 | | 2160 | | 2161 | | 2162 | | 2163 | | 2164 | | 2165 | | 2166 | | 2167 | | 2168 | | 2169 | | 2170 | | 2171 | | 2172 | | 2173 | | 2174 | | 2175 | | 2176 | | 2177 | | 2178 | | 2179 | | 2180 | | 2181 | | 2182 | | 2183 | | 2184 | | 2185 | | 2186 | | 2187 | | 2188 | | 2189 | | 2190 | | 2191 | | 2192 | | 2193 | | 2194 | | 2195 | | 2196 | | 2197 | | 2198 | | 2199 | | 2200 | | 2201 | | 2202 | | 2203 | | 2204 | | 2205 | | 2206 | | 2207 | | 2208 | | 2209 | | 2210 | | 2211 | | 2212 | | 2213 | | 2214 | | 2215 | | 2216 | | 2217 | | 2218 | | 2219 | | 2220 | | 2221 | | 2222 | | 2223 | | 2224 | | 2225 | | 2226 | | 2227 | | 2228 | | 2229 | | 2230 | | 2231 | | 2232 | | 2233 | | 2234 | | 2235 | | 2236 | | 2237 | | 2238 | | 2239 | | 2240 | | 2241 | | 2242 | | 2243 | | 2244 | | 2245 | | 2246 | | 2247 | | 2248 | | 2249 | | 2250 | | 2251 | | 2252 | | 2253 | | 2254 | | 2255 | | 2256 | | 2257 | | 2258 | | 2259 | | 2260 | | 2261 | | 2262 | | 2263 | | 2264 | | 2265 | | 2266 | | 2267 | | 2268 | | 2269 | | 2270 | | 2271 | | 2272 | | 2273 | | 2274 | | 2275 | | 2276 | | 2277 | | 2278 | | 2279 | | 2280 | | 2281 | | 2282 | | 2283 | | 2284 | | 2285 | | 2286 | | 2287 | | 2288 | | 2289 | | 2290 | | 2291 | | 2292 | | 2293 | | 2294 | | 2295 | | 2296 | | 2297 | | 2298 | | 2299 | | 2300 | | 2301 | | 2302 | | 2303 | | 2304 | | 2305 | | 2306 | | 2307 | | 2308 | | 2309 | | 2310 | | 2311 | | 2312 | | 2313 | | 2314 | | 2315 | | 2316 | | 2317 | | 2318 | | 2319 | | 2320 | | 2321 | | 2322 | | 2323 | | 2324 | | 2325 | | 2326 | | 2327 | | 2328 | | 2329 | | 2330 | | 2331 | | 2332 | | 2333 | | 2334 | | 2335 | | 2336 | | 2337 | | 2338 | | 2339 | | 2340 | | 2341 | | 2342 | | 2343 | | 2344 | | 2345 | | 2346 | | 2347 | | 2348 | | 2349 | | 2350 | | 2351 | | 2352 | | 2353 | | 2354 | | 2355 | | 2356 | | 2357 | | 2358 | | 2359 | | 2360 | | 2361 | | 2362 | | 2363 | | 2364 | | 2365 | | 2366 | | 2367 | | 2368 | | 2369 | | 2370 | | 2371 | | 2372 | | 2373 | | 2374 | | 2375 | | 2376 | | 2377 | | 2378 | | 2379 | | 2380 | | 2381 | | 2382 | | 2383 | | 2384 | | 2385 | | 2386 | | 2387 | | 2388 | | 2389 | | 2390 | | 2391 | | 2392 | | 2393 | | 2394 | | 2395 | | 2396 | | 2397 | | 2398 | | 2399 | | 2400 | | 2401 | | 2402 | | 2403 | | 2404 | | 2405 | | 2406 | | 2407 | | 2408 | | 2409 | |
|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|

| FOR
1 - STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR M | |
| VICTOR AUGUSTUS TRAUB JR. | | | | | | | | March 6, 1984 | | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Male | | White | | August 3, 1925 | | | | 58 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| New Jersey | | USA | | | | | | Baltimore County MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Towson | | 8001 Rider Avenue | | Disabled | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| Maryland | | Baltimore | | Towson | | | | 8001 Rider Avenue 21204 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Victor Augustus Traub, Sr. | | | | Audrey Fieger | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | |
| Yes | | WW II | | 143-18-4760 | | | | Mrs. Nancy Traub same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u>
4960
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Chronic obstructive pulmonary disease</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>80</u> , to <u>March 6</u> , 19 <u>84</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>March 5</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>D. William Schlott</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>3/6/84</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| D. William Schlott, M.D. | | | | 6 East Chase Street | | | | 21202 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 3-9-84 | | Mt. Pleasant | | | | Newark | | New Jersey | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Ruck Towson Funeral Home, Inc. | | | | 1050 York Road Towson, Md. 21204 | | | | MAR 9 1984 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Partial

3-2-34

St. Pleasant
Township, C. 21204

Newark

New Jersey

Victor

Augustine

Frank, Jr.

Indrey

Piegar

WM II

142-18-4760

disabled

New Jersey

August 3, 1933

SS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|-------------------------|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jay Tee Tribble | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
<input checked="" type="checkbox"/> 3 20 19 84 | | 2b. HOUR
M
10:45
am | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6-28-34 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
49 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3 20 19 84 | | 7d. HOUR
am | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. Carolina | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County | | | | 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8011 Norris Lane | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE
Md. | | | | 13b. CITY OR TOWN
Dundalk B.C. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8011 Norris Lane 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Eugene Tribble | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eunice Tribble | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT
ADDRESS
Maxine Tisdale 606 Glenrock RD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Smoke inhalation</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
7:25xx 3-20-1984 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
House fire. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
house | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
8011 Norris Lane Balto. Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Ann M. Dixon</i> | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED
3-20-84 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
3-24-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dundalk B.C. Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chas. A. Rice FSPA 1300 Eutaw Pl | | | | 25a. DATE RECEIVED BY REGISTRAR
MAR 28 1984 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical event must be certified at once.

BP 609
DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Nicholas Peter Tsendeas</u>
<u>Nicholas Tsendeas</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>Mar 23, 84</u> | | 2b. HOUR
<u>6 28 PM</u> | |
| 3. SEX
<u>MALE</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>11 14 17</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>66</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Greece</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>County Baltimore MD.</u> | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>St. Joseph 17620 York Rd</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Cab Driver</u> | |
| 13a. STATE
<u>Md.</u> | | 13b. COUNTY
<u>Baltimore</u> | | 13c. CITY OR TOWN
<u>Baltimore</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Peter Baltimore Tsendeas</u> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Kaliopi Gerondeas</u> | | 13e. STREET ADDRESS / ZIP CODE
<u>318 S. Stricker St. 21223</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
<u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>217-05-8141</u> | | 17. INFORMANT ADDRESS
<u>Debbie Sommer 1037 Hollins St. Balto.</u> | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<u>0000</u> IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest.</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Diabetic keto acidosis.</u> | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Fracture mandible</u> | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>M. Baker</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>M. BAKER.</u> | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>Mar. 26, 1984</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Westlawn Cem.</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Lowell Mass.</u> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>Leonard J. Ruck, Inc. Baltimore, Md.</u> | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<u>MAR 27 1984 Julia Davidson-Randall</u> | | | |

1965

Endorsement
Diabetes
Foster

M. BAKER
4

MAR 27 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06534

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARY Elizabeth Tuckey | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/15/84 | | | 2b. HOUR
2 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 19 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Towson-Maryland | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
STELLA MARIS HOSPICE Towson Md. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
at home | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Parkville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8714 Maravoss Lane 21234 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Albrecht | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Riegel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
214 12 0552 | | 17. INFORMANT
ADDRESS
family records | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Brain TumorAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1749
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

Secondary Breast Carcinoma

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1/83 to 3/15/84 , that (I) (we) last saw the deceased alive on 3/14/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Dr. K. Faulkner MD. | | | | DEGREE | | 22c. DATE SIGNED
3/15/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. K. Faulkner MD. | | | | 22e. ADDRESS
Stella Maris Hospice Towson Md. | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
3/17/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. County, MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Evans Chapel of Memories 8800 Harford Rd. | | | | 25a. DATE REC'D. BY REGISTRAR
March 23 1984 | | 25b. REGISTRAR'S SIGNATURE
W. Davidson-Randall | |

1/11/1914

11365

3/12/14

1/12/14

1/12/14

1/12/14

1/12/14

1/12/14

1/12/14

1/12/14

1/12/14

1/12/14

1/12/14

1/12/14

1/12/14

1/12/14

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 2 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|-------------------------|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Grason | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED March 31, 1984 | | 2b. HOUR | | 2c. DATE PRONOUNCED DEAD
March 31, 1984 | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 01 DAY 23 YEAR 1975 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 75 YRS. | | 7. IF UNDER 1 YR.
MONTHS 0 DAYS 0 | | 7c. DATE PRONOUNCED DEAD
March 31, 1984 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GBMC
6701 NORTH CHARLES STREET | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Judge | | 12b. KIND OF BUSINESS OR INDUSTRY
Judicial | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Sparks | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Systems
621 East Belfast Rd., 21152 | |
| 14. FATHER'S NAME
FIRST Henry MIDDLE Rutherford LAST Turnbull | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Elizabeth MIDDLE Risteau LAST Grason | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
1942-1946 | | 17. INFORMANT
21152 | | 17. ADDRESS
Mary K. Turnbull, 621 E. Belfast Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4292
Cardiac Arrest
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) HSCW
DUE TO, OR AS A CONSEQUENCE OF
(c) Sudden
31yr | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden
31yr | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Chas. F. O'Donnell | | | | TITLE (SPECIFY)
Deputy | | | | DATE SIGNED
3/31/84 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Chas. F. O'Donnell | | | | ADDRESS
7501 York Rd., 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
4/4/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Emmanuel Epis. Ch. Cem. Glencoe | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Martin D. Lawson | | | | 24. PHONE NO.
21093 | | 25a. DATE REC'D. BY REGISTRAR
APR 3 1984 | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |
| 26. ADDRESS OF FUNERAL HOME
Martin D. Lawson, 10 W. Padonia Rd. | | | | | | | | | | | |

11

72

LEE STREET

1-36-11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

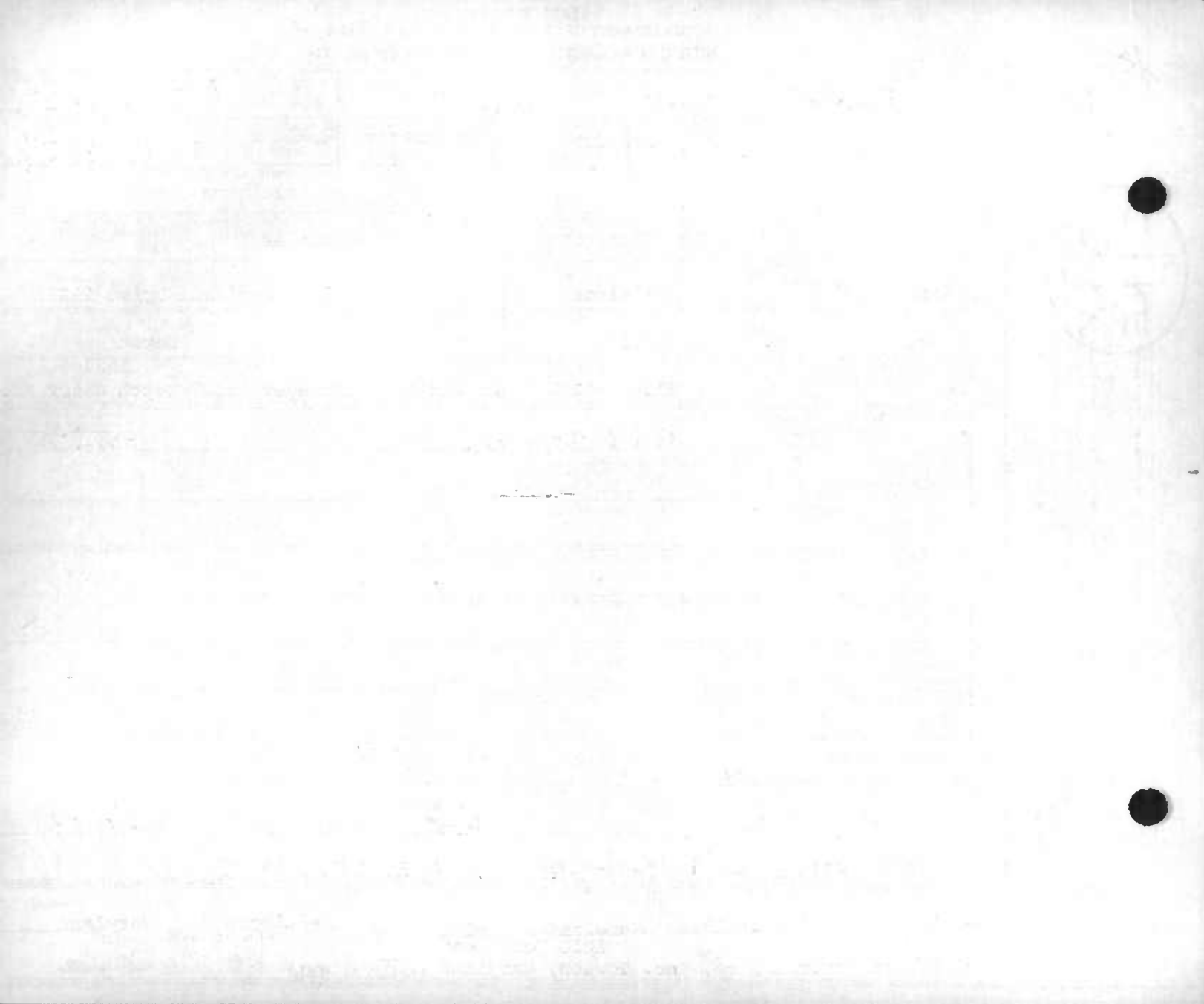
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|-------------------------|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FLORENCE E. TYLER | | 2a. DATE KNOWN OF DEATH 3 17 1984 | | 2b. HOUR 3 PM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 7, 1907 | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Pikesville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN HOSPITAL, GIVE STREET ADDRESS)
7013 Alden Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward M. Ulrich | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Horst | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-44-6277 | | 17. INFORMANT ADDRESS
21057 E. Ulrich Buddemeyer 11507 Notch Cliff Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4310 IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Stanley Z. Felsenberg | | TITLE (SPECIFY)
M.D. Deputy | | MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT)
STANLEY Z. Felsenberg MD | | ADDRESS 11 E. Chase St. 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-21-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. | | ADDRESS
1050 York Road | | 25a. DATE REC'D. BY REGISTRAR
MAR 19 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Randall | |

BALTIMORE MARYLAND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06537

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH J. VALACHOVIC | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAR 25/84 | | | 2b. HOUR
10 P.M. | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 7 1919 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
65 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3155 BAYBRIAR RD. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TRUCK DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | |
| 13a. STATE
MD | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
DUNDALK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
3155 BAYBRIAR RD. 21222 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
- VUK - | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
- VUK - | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES NO | | | | 16b. SOCIAL SECURITY NO.
079-12-8031 | |
| 16c. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES NO | | | 16d. SOCIAL SECURITY NO.
079-12-8031 | | | 17. INFORMANT
ADDRESS
EMMA DAVIS 3155 BAYBRIAR RD. 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of Bladder with Lung + bone + gland metastases</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>1889</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2-13-84 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of Bladder | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-8-1984 to 2-15-1984, that (I) (we) lost saw the deceased alive on 2-15-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-26-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGIE HERBIEKA MD. | | | | | | 22e. ADDRESS
7839 WISE AVE, Balt. Md 21222 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
3/28/84 | | 23c. NAME OF CEMETERY OR CREMATORY
CHURCHVILLE CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OBERLIN PA. | | | | |
| 24. FUNERAL DIRECTOR
NAME
CONNELLY FUNERAL HOME OF DUNDALK | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 29 1984 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
(AKA JOSEF JOHN VALIS)
Joseph W. VALIS JR. | | 2a. DATE OF DEATH MONTH DAY YEAR
March 19, 1984 | | 2b. HOUR
2:20a M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
MAY 13 1910 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANKLIN SQUARE HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PRINTER | |
| 12b. KIND OF BUSINESS OR INDUSTRY
PRINTING | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD. | | 13b. COUNTY
HARFORD | | 13c. CITY OR TOWN
FALLSTON | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2507 BURGUNDY DR. 21047 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOSEF W. VALIS SR. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNA PETERLIK | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-09-4080 | | 17. INFORMANT ADDRESS
MARIE VALIS (WIFE) SAME ADDRESS | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest, Renal Failure**

4281

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

(b) **Left Ventricular Failure**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from March 7 , 19 84 , to March 19 , 19 84 , that (we) lost
saw the deceased alive on March 19 , 19 84 , and that in (our) opinion death occurred on the date and hour and from the causes stated
above, (H) (we) (did) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. H. Mansah | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
03/19/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
QUANSA H M.D. | | | | 22e. ADDRESS
9000 Franklin Sq. Dr., 21237 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/22/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore MD. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
9705 Belair Rd., Balto. Md. 21236 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1984 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use on the burial-transit permits. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Frank Vicchio, Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 15, 1984 | | | 2b. HOUR
M
10 | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar. 21 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Perry Hall | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2 Dunhaven Place | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Green Spring Dairy | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Perry Hall | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2 Dunhaven Place 21236 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Pasquale Vicchio | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Angelina Aslovado | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
216 09 7336 | | 17. INFORMANT
ADDRESS
family records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ANEMIA
2898
DUE TO, OR AS A CONSEQUENCE OF
(b) MYELOFIBROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (b)
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE, PROSTATE CANCER | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Gary I. Cohen | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/16/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gary I. Cohen, M.D. | | | | 22e. ADDRESS
711 West 40th Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
burial | | 23b. DATE
3/19/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. County, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Evans Chapel of Memories | | | | ADDRESS
8800 Harford Road | | 25a. DATE REC'D. BY REGISTRAR
APR 23, 1984 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

BP

6
2

RECEIVED
MAY 19 1964



10/12

10/12

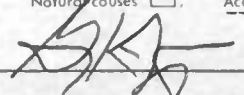
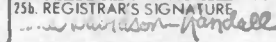
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

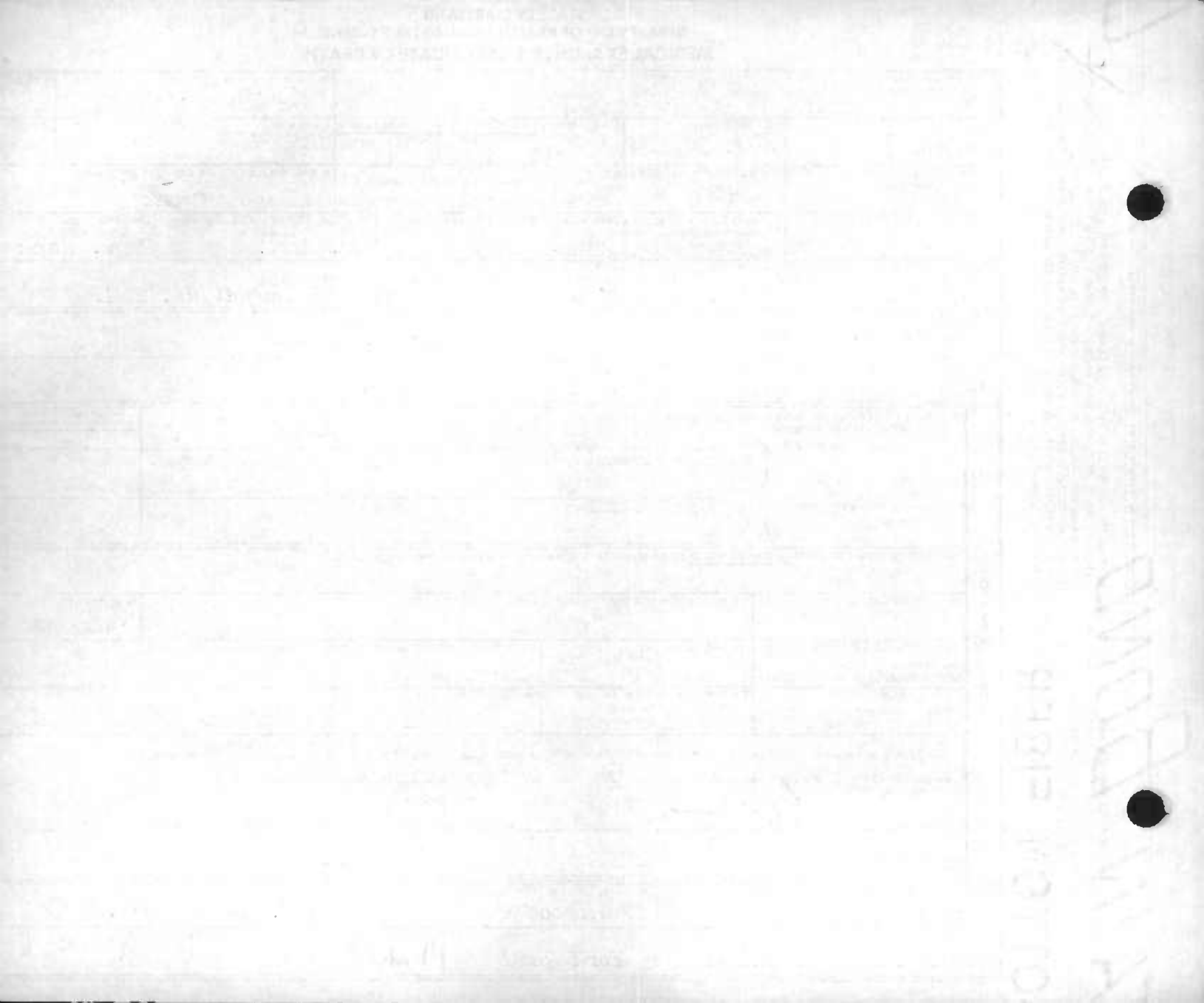
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|---------|---|--|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH DAY YEAR | | 2b. HOUR | | | |
| Trina | | Denise | | Via | | | | 3/21/84 | | | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 24 HRS | | 7c. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 2d. HOUR | | | |
| Female | White | Aug. 30 1958 | | 25 | | | | 3/21/84 | | | | 1:52 A M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | MD. | | | |
| Maryland | | USA | | | | Baltimore County | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Rossville | | Rt. 7 Near Mayflower Road | | Jr. Acct. | | Prov. Bank | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | Balto. | | Monkton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1001 Corbett Rd. 21111 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Ernest L. Grimes | | Patsy J. Grimes | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| no | | 213 70 1590 | | family | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Positional Asphyxia</u>
8150
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1:45xx 3/21/84 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver of auto, lost control, hit tree | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
roadway | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 7, Near Mayflower Rd., Rossville, Balto Co. Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 3/21/84 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
burial | | | | 23b. DATE
3/24/84 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. County, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Evans Chapel of Chimes 2325 York Road | | | | 25a. DATE REC'D. BY REGISTRAR
March 23 1984 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked other, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
GRACE C. VOGELSANG | | | 2a DATE OF DEATH
MONTH DAY YEAR
03 30 84 | | | 2b HOUR
5:20A.M. | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 29 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | |
| 10 CITY OR TOWN OF DEATH
CATONSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERIDIAN NURSING CENTER | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY
--- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
CATONSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
346 GREENLOW ROAD, 21228 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WALTER DORSEY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET O'BRIEN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
UNAVAILABLE | | 17 INFORMANT
ADDRESS
CAROLINE TOMALOVITZ 346 GREENLOW ROAD 21228 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u>
4292 DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. N/A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N/A | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>80</u> , to <u>March 30</u> 19 <u>84</u> , that (we) lost
saw the deceased alive on <u>March 20</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above (If (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Charles R. Graham, Jr.</u> | | | | DEGREE
MD | | | | 22c. DATE SIGNED
4/2/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES R. GRAHAM, M.D. | | | | 22e. ADDRESS
299 FREDERICK AVENUE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
04-02-84 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | | 23e. DATE REC'D. BY REGISTRAR | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
APR 2 1984 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|---|--|-----------------------------------|--|
| 1. FOR REGISTERAR THEODORE WAGA SR. | | | | | CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR HOUR | | | | |
| THEODORE WAGA SR. | | | | | 3 2 84 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | CAUCASIAN | | MONTH DAY YEAR | | 67 YRS. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. MD. | |
| NEW YORK | | USA | | | | BALTIMORE COUNTY | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ROSSVILLE | | FRANKLIN SQUARE EMERGENCY ROOM | | | | ROTH STEEL | | STEEL | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MD | | BALT. COUNTY | | WHITE HARBOR | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 5658 GUN POWDER RD | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | |
| STANISLAUS WAGA | | | | | CATHERINE SAJDA | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| YES | | | | | WW II | | LILLIAN WAGA 5658 GUNPOWDER RD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARREST - REFRACTORY VENTRICULAR FIBRILLATION</u> | | | | | | | | | |
| 4140 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) <u>CORONARY ARTERY DISEASE - S.P. CABG.</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC DISEASE</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| <u>HYPERTENSION; S.P. INFECTED M.I. 1981</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| 10/10/81 | | CORONARY ARTERY BYPASS | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>11/23/82</u> , 19____, to <u>PRESENT</u> , 19____, that (1) was lost saw the deceased alive or above, (1) was <u>did not</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | |
| <u>G. Weiner</u> | | | | | 3/2/84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| <u>GEORGE WEINER</u> | | | | | <u>CAREFIRST - 1005 N. POINT BLVD BALT. 21224</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | 3/16/84 | | GARDENS OF FAITH | | BALTO. BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| <u>John Cook</u> | | | | MAR 6 1984 | | <u>Johanna Davidson-Randall</u> | | | |

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7 7 3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 3-8-84 | | 4 45 | |
| 2. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | | WHITE | | MAY 1, 1900 | | 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | USA | | | | BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| RANDALLSTOWN | | BALTIMORE COUNTY GEN. HOSP. | | SALES | | LADIES WEAR | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | BALTO. | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| WOLF | | MOLLIE | | NO | | 217-03-0775 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 PNEUMONIA | | 17 COBBLESTONE CT. BALTO., MD | | 12125 | |
| DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST | | CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE LAST | | CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (c), STATING THE UNDERLYING CAUSE LAST | | CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (d), STATING THE UNDERLYING CAUSE LAST | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN COUNTY STATE | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-5-1984 to 3-8-1984 that (I) (we) last saw the deceased alive on 3-8-1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | 22d. DATE SIGNED | | | |
| Soonchul Hong | | | | 3-8-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| SOONCHUL HONG | | Baltimore County General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | MAR. 11, 1984 | | MOGAN ABRAHAM | | ROSEDALE COUNTY BALTO. MD | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS., INC. | | MAR 14 1984 | | Julia Davidson-Randall | | | |

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3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Joseph T. Walker</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>03 12 84</i> | | | 2b. HOUR
<i>22 35</i> M | | | | |
| 3. SEX
<i>MALE</i> | | 4. RACE
<i>BLACK</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>02 04 22</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>62</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
<i>VIRGINIA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>US</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Balto Co General Hosp</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>STEEL WORKER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>MARYLAND</i> | | | 13b. COUNTY
<i>BALTIMORE</i> | | 13c. CITY OR TOWN
<i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>7801 GAYWOOD CIRCLE 21207</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>EPHREM WALKER</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>BETTY TAYLOR</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>YES</i> | | | 16b. SOCIAL SECURITY NO.
<i>223-20 1085</i> | | 17. INFORMANT ADDRESS
<i>RACHEL WALKER 7801 GAYWOOD CIRCLE 21207</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary pulmonary arrest</i>
<i>4960</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>COPD</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 hr</i>
<i>20 years</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>11 4 84</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>5400 OLD COURT RD BALTIMORE MARYLAND</i> | | | | | |
| 22a. I certify that (i) this hospital attended the deceased from <i>2-23</i> 19 <i>84</i> , to <i>3-12</i> 19 <i>84</i> , that (ii) (we) last saw the deceased alive on <i>2-23</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>M B Phillipp</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3-13-84</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>M B Phillipp</i> | | | 22e. ADDRESS
<i>5400 OLD COURT RD BALTIMORE</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>3-19-84</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>GARRISON FORREST</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTIMORE MARYLAND</i> | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>E.L. PHILLIPS 1721 N. MONROE ST</i> | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 14 1984</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--------|---|---|-----------------------------------|--|------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| MARIE | | F. | | WALLACE | March | | 3 | 1984 | 5:30 P.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | White | Merch 11, 1901 | | 82 | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | U.S.A. | | | Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Catonsville | Meridian Nursing Home | | | Housewife | | Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 5322 Clifton Avenue 21207 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Peter | | Reitz | | Catherine Schmid | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 213-44-8763 | | Catherine M. Hupfl Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Renal failure</u> | | | | | | | | | 6 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio sclerosis</u> | | | | | | | | | arterio |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ase</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> , 19 <u>64</u> , to <u>3/3</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/3</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| Cliff Ratliff | | M.D. | | | | | | 3/5/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Cliff Ratliff M.D. | | 5772 Westview Mall, Baltimore, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. STATE | |
| Burial | | 3/7/84 | | Lorraine Park Cemetery | | Woodlawn | | Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE RECD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Leroy M. & Russell C. Witzke Funeral Homes P.A. | | | | MAR 5 1984 | | Julia Davidson-Randall | | | |
| 1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY LOU WARD | | | | 2b. HOUR 7:30P _M | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR AUG 22 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N CHARLES ST | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MED. TECH. | | 12b. KIND OF BUSINESS OR INDUSTRY JOHNS HOPK. HOSP. | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN COCKEYSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 10331 MALCOM CIRCLE | | 13f. 21030 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN E. SHRUM | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA MCCOY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 195-22-4125 | | 17. INFORMANT ADDRESS FAMILY RECORD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1820 CARDIO RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) HISTORY OF ENDOMETRIAL CA 1980
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/8 1984, to 3/8 1984, that (I) (we) lost soul the deceased alive on 3/8 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] MD | | | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. J. BALDANZA | | | | 22e. ADDRESS 10629 York Rd | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 3/13/84 | | 23c. NAME OF CEMETERY OR CREMATORY ALTO-RESTE PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALLEGANY TOWNSHIP, COUNTY PA. | |
| 24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF CHIMES | | | | 25a. DATE REC'D. BY REGISTRAR 2325 YORK RD | | 25b. REGISTRAR'S SIGNATURE MAR 15 1984 Julia Davidson-Rendell | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | DAYLIGHT SAVINGS | | |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| FIRST MIDDLE LAST | | | | | ELIZABETH C WARNS | | | | | MONTH DAY YEAR | | 1057A | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| Female | | | | | White | | | | | MONTH DAY YEAR | | 88 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | | | | | U.S.A. | | | | | Jan. 2, 1896 | | BALTIMORE COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| TOWSON | | | | | ST. JOSEPH HOSPITAL | | | | | Housewife | | Home | | |
| 13a. STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | | | Baltimore | | | | | 21204 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | 1654 Mussula Rd. 21204 | | | | |
| Edward French | | | | | Annie Lavery | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | ADDRESS | | |
| No | | | | | 218-14-7597 | | | | | Marie C. Ward | | 1654 Mussula Rd. 21204 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aged</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | | 3/20/84 | | |
| Lawrence Boas MD | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | |
| Burial | | | | | Mar. 22, '84 | | | | | Holy Redeemer Cemetery Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE RECEIVED BY REGISTRAR | | | | | 25b. SIGNATURE | | | | |
| NAME | | | | | ADDRESS | | | | | MAR 21 1984 | | | | |
| William E. Johnson | | | | | 8521 Loch Raven Blvd. | | | | | one Davidson | | | | |

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10-11-13

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

0 6 5 4 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)FIRST
LOUIS

MIDDLE

Alvin

LAST

WATTERS

2a. DATE OF DEATH

MONTH

DAY

YEAR

03 17 84

2b. HOUR

7:50AM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

Oct 23 1900

YEAR

6. AGE (IN YEARS LAST BIRTHDAY)

83

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE COUNTY

MD.

10. CITY OR TOWN OF DEATH

TOWSON, MD.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

GBMC-6701 N. CHARLES ST.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Machinist

12b. KIND OF BUSINESS OR INDUSTRY

Black & Decker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Balto.

13c. CITY OR TOWN

Cockeysville

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

201 Sherwood Road 21030

14. FATHER'S NAME

Walter Watters

15. MOTHER'S MAIDEN NAME

Lillie Spamer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

no

16b. SOCIAL SECURITY NO.

212 10 9321A

17. INFORMANT

ADDRESS

family records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY ARREST

2050

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c) ACUTE MYELOCYTE LEUKEMIA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-14 to 3-17 1984, that (I) (we) lost saw the deceased alive on 3-17 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Mark Davis

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

3/17/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

MARK C. DAVIS

22e. ADDRESS

GBMC-6701 N. CHARLES ST. 21204

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

burial

23b. DATE

3/19/84

23c. NAME OF CEMETERY OR CREMATORY

Poplar Grove

23d. LOCATION
CITY OR TOWN

Balto. County, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME Evans Chapel of Chimes 2325 York Road ADDRESS

25a. DATE REC'D. BY REGISTRAR

MAR 23 1984

25b. REGISTRAR'S SIGNATURE

Lena Davidson-Handell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LOUIS

W TTERS

03 17 84 7:50AM

BALTIMORE COUNTY

TOWSON, MD. 66MC-6701 N. CHARLES ST.

RESPIRATORY ARREST

PNEUMONIA

ACUTE MYELOCYTE LEUKEMIA

3-17

3-17

3-17

3-17

3-17

3/17/84

MARK C. DAVIS

66MC-6701 N. CHARLES ST. 21504

TO REMAIN BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06549

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM Everett WAUGH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 08 '84 | | 2b. HOUR
5:00A
M |
| 3. SEX
MALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2/6/1909 | 6. AGE (IN YEARS LAST BIRTHDAY)
75
YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH A CITY, GIVE STREET ADDRESS)
GBMC-6701 N. CHARLES ST. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Driver-Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
Balto. | | |
| 13c. CITY OR TOWN
Balto. City | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur S. Waugh | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Susie Keene | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
Navy | 17. INFORMANT
ADDRESS
Hilda M. Waugh, 4000 Overlea Ave.
Balto., 21206 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
1519
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
GASTRIC CA | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
2/15 84 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3/08 84 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15 84, to 3/08 84, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Mary Ann D. Moore MD | | | | 22c. DATE SIGNED
8-8-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARY ANN D. MOORE, M.D. | | | | 22e. ADDRESS
GBMC-6701 N. CHARLES ST. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/10/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill | |
| 23d. LOCATION
CITY OR TOWN
Balto. | | 23e. COUNTY
Balto. | | 23f. STATE
MD | |
| 24. FUNERAL DIRECTOR
John C. Miller, Inc. 6415 Belair Rd. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1984 | |

2:00 PM 10/10/00

WILLIAM BARRETT WARD

MALE

75

2/10/00

CANTON, MASS

1000 WEST 10TH STREET

CHICAGO, ILL. 60607

OVER 100

1000 WEST 10TH STREET

CHICAGO

1000

1000 WEST 10TH STREET

CHICAGO, ILL.

CHICAGO, ILL.

X

100

1000

100

2/10

MARY ANN D. WARD, M.D.

1000 WEST 10TH STREET

CHICAGO, ILL. 60607

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Hugh C. Weatherford | | | | 2b. HOUR
6:05p M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 29, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH
Reisterstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bent Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Cement Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Anne Arundel Brooklyn | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Vival Stokes Weatherford | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Opie White | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
227-05-1100 | | 17. INFORMANT ADDRESS
403 West Maple Road, Andrew Sass Linthicum, Md. 21090 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident old
4380
DUE TO, OR AS A CONSEQUENCE OF (b) Accident - Coccyx area - large
DUE TO, OR AS A CONSEQUENCE OF (c) 1 month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 3-11-84 to 3-11-84 , that (I) (we) last saw the deceased alive on 3-11-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
C.E. McWilliams | | | | 22c. DATE SIGNED
3-11-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C.E. McWilliams | | | | 22e. ADDRESS
11904 Reisterstown Rd Reisterstown Md. 21136 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Mar. 14, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Fork Protestant Epis. Ch. Cem. Ashland, Hanover Co. Va. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
1 | |
| 24. FUNERAL DIRECTOR NAME
H.G. Eickhardt | | | | 25a. DATE REC'D BY REGISTRAR
MAR 16 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

BP

10E5

20%

RECEIVED

OFFICE

| | | | | | |
|--------------------------------|--------------------|-------------------------------|---------------------|----------------|-------|
| Male | White | Pop. 29,190 | 70 | March 11, 1964 | 6:05P |
| Virginia | U.S.A. | X | Baltimore County | | |
| Religion | East Mainline Home | | Truck Driver | Kennett Co. | |
| Maryland Anne Arundel Brooklyn | X | | 525 Holy Cross Road | 11232 | |
| Vival | Craker | Westchester | 405 West Main Road | 103 | |
| No | 227-07-1100 | Andrew Sean Linton, No. 21090 | | | |

Mar 11, 1964 York Protestant ...
MAR 16 1964 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06551

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ERNEST WEBER | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 13, 1984 | | | 2b. HOUR
12:05 A | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 2, 1906 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY, MD. | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MasterPlumber | |
| 13a. STATE
Maryland | | 13b. COUNTY
Harford | | 13c. CITY OR TOWN
Baldwin | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
2535 Greene Rd. 21013 | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Justina Stoddler | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-01-6970 | | 17. INFORMANT ADDRESS
Irma C. Shanahan Baldwin, MD 21013 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Cancer
1991
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Natividad S. de Leon, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/13/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
Burial | | 23b. DATE
Mar. 15, '84 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery Baltimore, Maryland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William E. Johnson 8521 Loch Raven Blvd. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randell | |

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06552

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|-------------------------|--|---|---|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BEATRICE WEINBERGER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 1, 1984 | | 2b. HOUR
5:44 A.M. | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 26, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | 10. CITY OR TOWN OF DEATH
PIKESVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5 POMONA NORTH APT. 4 (21208) | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 13. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
PIKESVILLE | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MAX PLANNER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DINAH UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
112-07-3443A | | 17. INFORMANT
ADDRESS
SEYMOUR WEINBERGER 5 POMONA NORTH, APT. 4 (21208) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC OVARIAN CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Thomas Brown MD | | DEGREE | | 22c. DATE SIGNED
3/1/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. THOMAS BROWN | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/2/84 | | 23c. NAME OF CEMETERY OR CREMATORY
OHEB SHALOM MEM. PARK REISTERSTOWN | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 6 1984 | | 25b. REGISTRAR'S SIGNATURE
John A. Anderson | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medicolegal case should be forwarded at once.

BP

1815

DOWN

3

2000

UP

MAR 8 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 11 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|---|--|--|-------------------------------------|---|
| 1. FOR STATE REGISTRAR | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Annie Marie WELLES | | | | | March 10, 1984 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 2b. HOUR |
| Female | | White | | 2 8 05 | | 5:36p. M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR (MONTHS) DAYS |
| Maryland | | USA | | 79 | | IF UNDER 24 HRS. (HOURS) MIN. |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Rossville | | Franklin Square Hospital | | | | Baltimore County MD. |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. CITY OR TOWN | | 13b. STREET ADDRESS / ZIP CODE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Maryland | | Baltimore | | 1250 Narcissus Ave. 21237 | | homemaking |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Charles Slater | | | Bertha M. Hasse | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | 218-40-7718A | | 7938 Rolling View Balto., Md. 21236 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>A.S.H.D.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| Samuel Stern, M.D. | | Fuller Medical Ctr. Ridge Rd. 687-4400 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | 3-14-84 | | Parkwood Cemetery | | Baltimore, Md. |
| 24. FUNERAL DIRECTOR NAME | | 7401 Belair Rd. Balto., Md. 21236 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Lassahn Funeral Home | | | | MAR 16 1984 | | Julia Davidson-Randall |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|---|---|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
sara T. WELTY | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 9, 1984 | | 2b. HOUR
8:35P M | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
9/28/19 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | 7. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
ROSSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANKLIN SQ | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HSWE | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET ADDRESS / ZIP CODE
21221
931 MIDDLESEX RD | | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
14a. STATE
MD. | | 14b. COUNTY
BALTO | | 14c. CITY OR TOWN
ESSEX | | |
| 15. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES DEETS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
THERESA ORMAND | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
21512 2745 | | 17. INFORMANT
ADDRESS
GEORGE WELTY ABOVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4860 Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia and Septicemia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
P.M. 19 | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 4, 1984, to March 9, 1984, that (I) (we) last saw the deceased alive on March 9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
J. G. Connelly | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
QUANSA H | | 22e. ADDRESS
9000 Franklin Square Drive - 21237 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/13/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | | 24. FUNERAL DIRECTOR
NAME ADDRESS
J. G. CONNELLY 300 MALE | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
MAR 14 1984 Julia Davidson-Randall | | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|------------------------------------|--|---|---|--|-----------------------------------|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| | | SUSAN P. WHARTON | | | | | 3 | 11 | 84 | | 10 ²⁵ PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | Feb. 26, 1929 | | 55 | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| VA | | USA | | | | Baltimore County MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Randallstown | | Baltimore County General Hsp. | | | | | | Homemaker | | Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| | | MD | | Balto. | | Owings Mills | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 311 Chattolane Hill 21117 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| William Armistead Pendleton | | | | Elsie Hunn | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | 216 34 4810 | | John Gill Wharton, | | | | Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> | | | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>ACUTE MYOCARDIAL INFARCTION</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | CITY OR TOWN COUNTY STATE | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | STREET | | | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>3-9</u> , 19 <u>84</u> , to <u>3-11</u> , 19 <u>84</u> , that (I) <u>(we)</u> lost saw the deceased <u>live on</u> <u>3-11</u> , 19 <u>84</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | |
| <u>[Signature]</u> | | | MD | | | | | | 3-11-84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| R. DEPESTRE | | | BALTIMORE COUNTY GENERAL HOSP. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| Burial | | | 3/15/84 | | St. Thomas | | | Garrison Forest, MD | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| NAME ADDRESS | | | | | | | | | | | |
| Henry W. Jenkins & Sons Co. | | | | | | MAR 14 1984 | | | <u>[Signature]</u> | | |
| 4905 York Road Balto., MD 21212 | | | | | | | | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2015-2016

.00 2000 1000 500 .

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

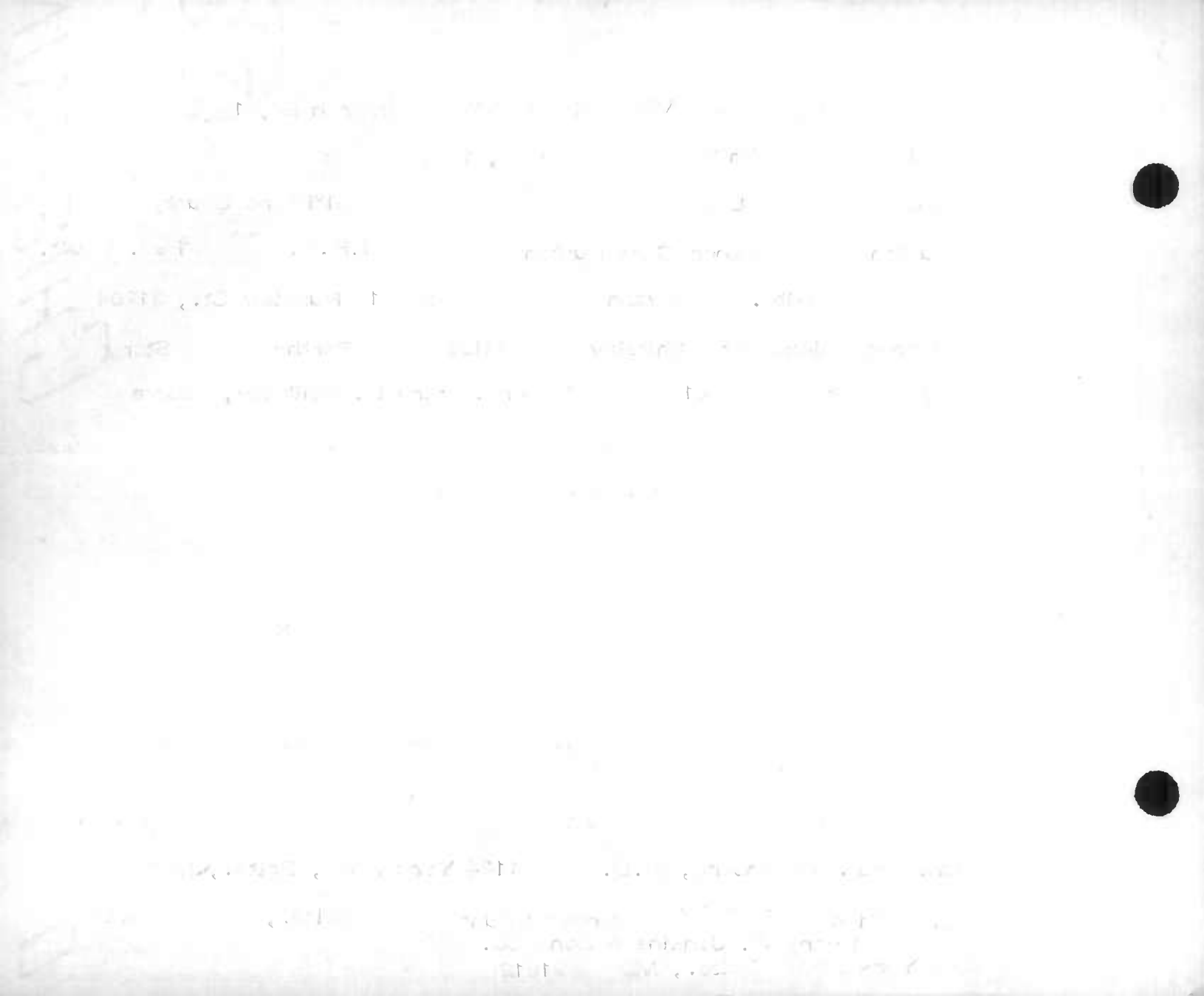
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE CALVIN WHITELEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 24, 1984 | | 2b. HOUR
6:25 P.M. | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 28, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Ruxton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Manor Care Ruxton | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
I.R.S. | | 12b. KIND OF BUSINESS OR INDUSTRY
Fed. Gov't. | | |
| 13a. STATE
MD | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
12 Ruxview Ct., 21204 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Alexander Whiteley | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Bertha Story | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
VV I 218 36 9241 | | 17. INFORMANT
ADDRESS
Mrs. Mary H. Whiteley, Same | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) aspiration pneumonia
3320
DUE TO, OR AS A CONSEQUENCE OF
(b) Parkinson's disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Mar 3, 1984 to Mar 24, 1984 , that (I) (we) lost saw the deceased alive on Mar 22, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Bruce Rosenberg | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/26/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Bruce Rosenberg, M.D. | | | | 22e. ADDRESS
1134 York Road, Balto., MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
3/27/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., MD | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Handell | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed in the envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, 19, 20, any injury, or other traumatic event, no medical certificate may be submitted.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR XC 2 228 9124 | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
BENJAMIN F. WHITTINGTON | | | | 2b. HOUR
12:53 P | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
AUGUST 14, 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
54 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF KNOWN, GIVE FACILITY AND STREET ADDRESS)
V.A.M.C., FORT HOWARD, MARYLAND | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Painter | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MARYLAND A.A. ANNAPOLIS | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
P.O. BOX 4216 21403 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Benjamin Franklin Whittington | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Florence Burl | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE DATES)
YES KOREAN | | 16b. SOCIAL SECURITY NO.
217 34 9635 | | 17. INFORMANT ADDRESS
CLINICAL RECORD, VAMC, FORT HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES |
| 4275 } CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS, ATRIAL FIBRILLATION | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 16 83 to MARCH 18 84, that (I) (we) last saw the deceased alive on MARCH 18 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Marcia Good MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/18/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCIA GOOD, M.D. | | | | 22e. ADDRESS
VAMC, FORT HOWARD, MARYLAND 21052 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Mar 21, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland Veteran | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Crownsville A.A. MD | |
| 24. FUNERAL DIRECTOR NAME
Taylor Funeral Chapel-Annapolis, MD | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 21 1984 | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 OR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

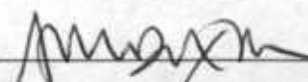
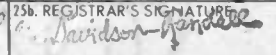
BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|-------------------------|--|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MICHAEL HOWARD WILES | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
3 29 19 84 | | | 2b. HOUR
2:10 a.m. | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
August 7, 1952 | 6. AGE (IN YEARS)
LAST BIRTHDAY
31 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3 29 19 84 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH
Baynesville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Oakleigh Rd. no. of Redwood | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Maintenance Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Hecht Co. | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert A. Wiles, Sr. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna C. Crews | | | 13e. STREET ADDRESS
1816 Darrich Dr. - 21234 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
213-60-2443 | | 17. INFORMANT ADDRESS
Robert A. Wiles, Sr. - Same as #13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries
8150
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a. | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1:45xx 3-29- 19 84 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Driver in auto/fixed object impact. | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE
Oakleigh Rd. no. of Redwood Balto. Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
 | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | DATE SIGNED 3-29-84 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-2-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parkville Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | 25a. DATE REC'D. BY REGISTRAR
APR 3 1984 | | | 25b. REGISTRAR'S SIGNATURE
 | | |

Funeral Home, Inc. 1030 York Rd. 1030 York Rd.

Funeral Home, Inc. 1030 York Rd. 1030 York Rd.

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Funeral Home, Inc. 1030 York Rd. 1030 York Rd.

Funeral Home, Inc. 1030 York Rd. 1030 York Rd.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ROSALIE J. WILHELM | | | | March 3, 1984 M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
June 27, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
55 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH
Lutherville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
115 W. Seminary Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Lutherville | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Lawrence M. Caples | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary E. Heins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-24-0193 | | 17. INFORMANT ADDRESS
George L. Wilhelm 115 W. Seminary Ave. 21093 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Lung Carcinoma</u>
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>Nov 14, 1983</u> to <u>March 3, 1984</u> , that (ii) (we) last saw the deceased alive on <u>Jan 30, 1984</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE <u>Charles Padgett, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>3/5/84</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles Padgett, M.D. | | | | 22e. ADDRESS
5601 Loch Raven Blvd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-7-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Jessop Methodist | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Sparks Maryland | |
| 24. FUNERAL DIRECTOR
NAME Ruck Towson Funeral Home, Inc. ADDRESS Towson, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 6 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | |

2004

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 6 3 6 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES F. WILLIAMS | | | 2a. DATE OF DEATH
MONTH DAY YEAR 3/24/84 | | 2b. HOUR
11:25^P | | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR 8/10/10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6701 N. CHARLES ST GBMC | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5925 Bertram Ave. 21214 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James E. Williams | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eula Himelright | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE YEAR OR DATES)
Yes WWII | | 16b. SOCIAL SECURITY NO.
212-09-3541 | | 17. INFORMANT
ADDRESS
Anna Williams, Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
1550
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HEPATOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/24 , 19 84 , to 3/24 , 19 84 , that (I) (we) last saw the deceased alive on 3/24 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>M. Davis</i> | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/25/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. M. DAVIS | | | 22e. ADDRESS
GBMC | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3-28-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 27 1984 Julia Davidson-Randall | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06561

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ida Gertrude WILSON | | | 2a. DATE OF DEATH
MONTH March DAY 11 YEAR 1984 2b. HOUR 5:30A M | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH Dec. DAY 8 YEAR 1891 | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 8b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH
Rossville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Square Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MD. | | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Dundalk | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST Jeremiah MIDDLE D. LAST Brown | | | 15. MOTHER'S MAIDEN NAME
FIRST Sarah MIDDLE LAST Reighard | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
212.05.6951D | 17. INFORMANT
ADDRESS A. Jane Rudd (Daughter) (Same as 13e) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest;
Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 9 , 19 84 , to March 11 , 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 11 , 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Delahunty | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/11/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Delahunty | | 22e. ADDRESS
9000 Franklin Square Drive, 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY Burial | 23b. DATE
3/13/1984 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN Baltimore COUNTY STATE Maryland | |
| 24. FUNERAL DIRECTOR
NAME Walter Brooks Bradley Inc., Dundalk, Md. 21222 ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR MAR 13 1984 25b. REGISTRAR'S SIGNATURE J. R. [Signature] | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06562

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|---|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John F Windhaus | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 31 84 | | | 2b. HOUR
0356M | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
05 25 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore Co. Gen. Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Maintenance | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Balto. Bus. Forms | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Reisterstown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
305 Academy Avenue 21136 | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frederick Windhaus | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth ? | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-07-1016A 215-07-1016A | | 17. INFORMANT
ADDRESS
305 Academy Avenue
Mrs. Regina A. Horvath, Reisterstown, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the lung
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-25 1984 to April 1984, that (I) (we) last saw the deceased alive on 2-1 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Rafael Perez-Mera | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-2-84 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
RAFAEL PEREZ-MERA | | | | 22e. ADDRESS
5400 Old Court Rd 21133 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Apr. 3, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
H. G. Schindt | | | | ADDRESS
Owings Mills, Md. | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If a medical examiner is required, the certificate must be signed by the medical examiner within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
HELEN M. WOJCIK | | | | 3-5-84 12:30 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
April 12 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
61 | |
| 7a. BIRTHPLACE (COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
ROSSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANKLIN SQUARE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Essex | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Walter - Kensicka | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Josephine - Komoda | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
218 09 1356 | | 17. INFORMANT ADDRESS
Thomas Colon 804 S. Streeper St. 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) METASTATIC SMALL CELL UNDIFFERENTIATED LUNG CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/14 , 19 84 , to 3/5 , 19 84 , that (I) (we) last saw the deceased alive on 3/4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) want the body after death. | | | | | | | |
| 22b. SIGNATURE
Leslie MUKALI | | | | DEGREE
MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/5/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LESLIE MUKALI | | | | 22e. ADDRESS
FRANKLIN SQUARE HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
March 8 '84 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Lilly & Zeiler, Inc. 1901 Eastern Ave. 21231 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 7 1984 <i>John Davidson-Randall</i> | | | |



[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, a medical examiner must be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 06564 | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mrs. Lillian W. Wolf | | | | 2a. DATE OF DEATH MONTH DAY YEAR March 25 1984 | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR July 31 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY --- | |
| 13a. STATE Maryland | | 13b. CITY Baltimore | | 13c. CITY OR TOWN Woodstock | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 2620 Offutt Rd. | | 13f. ZIP CODE 21163 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William N. Karcher Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rena Laib Karcher | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 217-07-6935 | | 17. INFIRMITY ADDRESS 2620 Offutt Rd. Woodstock Maryland | | 21163 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) --- | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Hafeez A Syed | | DEGREE | | 22c. DATE SIGNED 3/25/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFEEZ A SYED MD | | 22e. ADDRESS BALTIMORE COUNTY GEN HOSP | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 03-28-84 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Paran Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR MAR 27 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | |

BP.

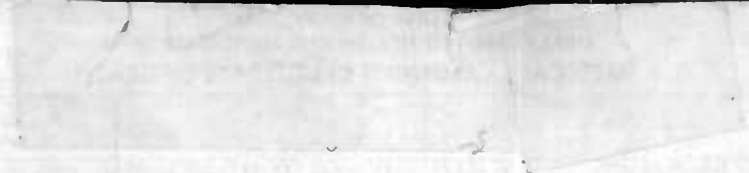
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 565 | |
|---|---------|------------------------------|---|--|------------------------------------|---|--|---|-----------------------------------|--|----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR |
| Virginia Sue Yarworth | | | | | | 3 13 19 84 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | 2d. HOUR |
| Female | White | Sept 30, 1929 | 54 1/2 YRS. | | | 3 13 19 84 | | | 10:45 a M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Kentucky | | U.S.A. | | | | Baltimore County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | 808 Providence Rd. (in front of) | | | Housewife | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Baltimore | | Towson | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1308 Highland Dr 21239 | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | | | | | FIRST MIDDLE LAST | | | | | |
| William C Engle | | | | | | Anna Foley | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | |
| No | | | | 290-26-1963 | | William J Yarworth | | | Same As 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cranio cerebral trauma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 10:30 M. 3 13 19 84 | | | | 3 13 19 84 | | Driver in auto/truck impact | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | |
| | | | | street | | in front of 808 Providence Rd., Balto Co, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| Thomas D. Smith, M.D. | | | | Deputy Chief | | | | 3/13/84 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Thomas D. Smith, M.D. | | | | 111 Penn St. | | | | Balto, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| Burial | | | 3/16/84 | | Holly Hill | | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| NAME ADDRESS | | | | | | MAR 15 1984 | | | John Davidson Randall | | |
| Leonard J Ruck Inc. Baltimore, Maryland | | | | | | | | | | | |

MEDICAL CERTIFICATION



RECEIVED

NOV 10 1960

11/10/60



Handwritten signature or initials inside an oval.

